Name: _____ DOB: _____

Address: _____ Height:_____

_____Weight:_____

Telephone: _____Alternate phone: _____

Email Address: _____Social Security Number: _____

Emergency Contact:_____ Relationship: _____ Telephone:_____

Allergies (medicine and/or food):

_____

☐ I have no allergies to medicine or food

Medications:	**Dose:**	**How often:**

Personal Medical History (please circle or check all that you have or have had personally):

Allergies	Congestive Heart Failure	Hepatitis A	Phlebitis
Anemia	COPD	Hepatitis B	Psoriasis
Anticoagulation Use	CVA (stroke)	Hepatitis C	Renal (kidney) stone
Anxiety	Deep Vein Thrombosis	Herniation of disc	Rheumatoid Arthritis
Arrhythmia	Diabetes	HIV	Sciatica
Arthritis	Eczema	Hypercholesterolemia	Sickle Cell Disease
Asthma	Edema	Hypertension	Sickle Cell Trait
Atrial Fibrillation	Endocarditis	Hyperthyroidism	Skin Cancer
Blood Clotting disorder	Fibromyalgia	Hypothyroidism	Stomach Ulcer
Factor V Leiden	GERD (acid reflux)	Jaundice	Superficial Phlebitis
Cancer	Glaucoma	Lupus	Syphilis
Cardiomyopathy	Gonorrhea	Lyme Disease	Vision Problems
Chronic Kidney Disease	Hearing Impaired	Macular Disease	Other:
Cirrhosis of Liver	Heart Attack	Osteoarthritis	Other:
Cirrhosis of Pancreas	Heart Valve Disorder	Peripheral Vascular Disease	Other:

Name: _____

Family History: (please circle and to the right of the condition, state who and age of death if no longer alive.)

Alcoholism			Clubfoot			Hypertension		
Amputation above knee			Connective Tissue Disease			Ingrown toenail		
Amputation below knee			Deep Vein Thrombosis			Muscular Dystrophy		
Ankylosing Spondylitis			Diabetes mellitus			Peripheral Vascular Disease		
Aortic Aneurysm			Fibromyalgia			Renal Disease		
Bunion			Gastric Ulcer			Rheumatic Fever		
CVA (stroke)			Heart Attack			Rheumatoid Arthritis		
Cancer			Heart Disease			Sickle Cell Anemia		
Cardiac Pacemaker			Heart Valve Disorder			Sickle Cell Anemia		
Charcot-Marie-Tooth Disease			Hypercholesterolemia					

Social History:

Occupation:	Marital Status: S M D W	Exercise:
Tobacco Use: Yes No	Alcohol Use: Yes No	Special Diet:
Packs/day? How many years?	How Often: daily 1-2/week	Street Drugs: Yes No
Past Use: Yes No	1-2/month 1-2/year	How Often:
If so, when did you quit?	Amount per episode:	Amount:
	Type:	Type:

Surgical History: (Please list any surgical procedures you have had. These include tonsillectomy, wisdom teeth, cardiac procedures and joint replacements, to name a few.)

Preferred Pharmacy and Location: _____

My signature below acknowledges that I was offered the opportunity to view the office's privacy policy regarding my medical records (HIPAA) and that I authorize evaluation and treatment by the physician. I also authorize the office to submit claims directly to my insurance company. I also acknowledge that I am responsible to for all deductibles and/or copays as per my insurance guidelines.

X _____ Date: _____

****Please note that you cannot be seen by the physician until this form is signed as it is consent for treatment.****