Patient Health Information

Patient Name _____
First Middle Last

Birth date _____ Age _____ Sex _____ SS# _____ or last 4 of SS# _____

Street Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Marital Status (circle): Single - Married - Divorced – Separated - Widowed

Race/Ethnicity (circle): Caucasian - African American - American Indian - Asian
Native Hawaiian or Pac. Islander - Multi-Racial - Hispanic

Employer/Occupation: _____

Referred By: _____

Primary Care Physician _____ Last Exam _____

Primary Insurance: _____ Secondary: _____

Insured Name (if not patient) _____ Birth date _____

Relationship to patient _____ SS# _____

Emergency Contact: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Reason for Visit: _____

Patient Health Information

Past Medical History (circle)

Anemia	Y	N	Heart Attack	Y	N	Hepatitis	Y	N
Anxiety	Y	N	High Blood Pressure	Y	N	Aids/HIV	Y	N
Asthma	Y	N	Kidney Stones	Y	N			
Bleeding Disorder	Y	N	Skin Cancer	Y	N			
			Stroke	Y	N			
Cancer	Y	N	Thyroid Disorder	Y	N			
Type: _____			Misc: _____					
Diabetes	Y	N	_____					

Past Surgeries/Significant Illness

Procedure	Date	Surgeon

Any Significant Family History/Illness: _____

List All Allergies

Reactions to medications, drugs, suture, tape and Type of reaction (i.e., hives, rash, and breathing disorders)

Allergy	Reaction	Allergy	Reaction

List All Medications

Please list all medications, over the counter, herbal medications, diet pills, birth control.

Medication	Dose	Medication	Dose

Social History

Height: _____ Weight: _____

(please circle)

Smoking: Y N Alcohol: daily - social - never Exercise: _____days a week

How Much: _____ Cardio – walking- weights -yoga

Female Patients: Pregnant Y N Lactating: Y N