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LAST NAME		FIRST NAME		MIDDLE INITIAL
STREET ADDRESS		APT # / CITY, STATE		ZIP CODE
SEX	BIRTHDATE / /	SOCIAL SECURITY NUMBER - -		DRIVER'S LICENSE #
EMAIL ADDRESS		HOME TELEPHONE #		CELL PHONE #
EMPLOYMENT INFORMATION				
EMPLOYERS NAME				TELEPHONE #
STREET ADDRESS		CITY, STATE		ZIP CODE
INSURANCE INFORMATION				
INSURANCE COMPANY (PRIMARY)				
INSURANCE COMPANY ADDRESS		CITY, STATE		ZIP CODE
GROUP/POLICY #	INSURED NAME (IF NOT PATIENT)		RELATIONSHIP TO PATIENT	
WHO REFERRED YOU TO THIS OFFICE?				
PERSON TO CONTACT IN CASE OF EMERGENCY:				
STREET ADDRESS		APT # / CITY, STATE		ZIP CODE
TELEPHONE #			RELATIONSHIP TO YOU	

TO OUR PATIENTS: ALL PATIENTS, INCLUDING THOSE WITH INSURANCE, ARE EXPECTED TO BE RESPONSIBLE FOR PAYMENT OF THE DOCTORS FEE. WE WILL BE GLAD TO ASSIST YOU IN OBTAINING PAYMENT FROM YOUR INSURANCE COMPANY.

IT IS CUSTOMARY FOR ALL PROFESSIONAL SERVICES TO BE PAID FOR WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE OFFICE MANAGER.

SIGNATURE OF PATIENT OF RESPONSIBLE PARTY: _____

PATIENT PERSONAL HEALTH HISTORY

Name: _____

Date of Birth: _____

Have you ever had any of the following conditions: If uncertain, leave blank.

Aids or Hiv+	No	Yes	Hives	No	Yes
Anemia	No	Yes	Infectious Mono	No	Yes
Arthritis	No	Yes	Kidney Disease	No	Yes
Asthma	No	Yes	Low Blood Pressure	No	Yes
Back Trouble	No	Yes	Measles	No	Yes
Bladder Infection	No	Yes	Migraine Headaches	No	Yes
Bleeding Tendency	No	Yes	Mitral Valve Prolapse	No	Yes
Blood or Plasma Transfusions	No	Yes	Mumps	No	Yes
Bronchitis	No	Yes	Pneumonia	No	Yes
Cancer	No	Yes	Polio	No	Yes
Chicken Pox	No	Yes	Rheumatic Fever	No	Yes
Diabetes	No	Yes	Scarlet Fever	No	Yes
Diphtheria	No	Yes	Smallpox	No	Yes
Epilepsy	No	Yes	Stroke	No	Yes
Glaucoma	No	Yes	Thyroid Disease	No	Yes
Heart Disease	No	Yes	Tuberculosis	No	Yes
Hemorrhoids	No	Yes	Ulcer	No	Yes
Hepatitis	No	Yes	Venereal Disease	No	Yes
Hernia	No	Yes	Whooping Cough	No	Yes
High Blood Pressure	No	Yes			

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

CARDIOVASCULAR

Heart Trouble	No	Yes
Chest Pain	No	Yes
Shortness of breath	No	Yes
Swelling of feet/ankles/hands	No	Yes
Chronic or frequent coughs	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles/joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss/ringing	No	Yes
Earaches/drainage	No	Yes
Sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

