Patient: ___ ___________

Date: ___________

PERSONAL INFORMATION		
AGE:	DOB:	___MALE ___FEMALE
ADDRESS:		
CITY, STATE, ZIPCODE:		
HOME #:	OCCUPATION:	
WORK#:	EMERGENCY #:	
HOW DID YOU HEAR ABOUT US?		
MARITAL STATUS:	SPOUSE'S NAME:	AGE:

ALLERGIES TO MEDICATION,X-RAY DYES, OR OTHER SUBSTANCES

IF YES, PLEASE LIST NAME(S) OF MEDICINES AND TYPES OF REACTION(S):

	DRUG NAME	REACTION		DRUG NAME	REACTION
1.	___	___	3.	___	___
2.	___	___	4.	___	___

MEDICATIONS (PRESCRIPTIONS OVER THE COUNTER, VITAMINS, HERBS , ETC)

	DRUG NAME	DOSE		DRUG NAME	DOSE
1.	___	___	5.	___	___
2.	___	___	6.	___	___
3.	___	___	7.	___	___
4.	___	___	8.	___	___

PAST MEDICAL HISTORY TREATED OR UNTREATED

HOSPITALIZATIONS

	SURGICAL	DATE		SURGICAL	DATE
1.	___	___	4.	___	___
2.	___	___	5.	___	___
3.	___	___	6.	___	___

IMMUNIZATION HISTORY

HEPATITIS B ___ NO ___ YES	PNEUMOVAX ___ NO ___ YES
FLU ___ NO ___ YES	TETANUS ___ NO ___ YES
OTHER ___________	HEPATITUS A ___ NO ___ YES

PREVENTIVE

	DATE		DATE		DATE
SIGMOIDOSCOPY:	________	PAP SMEAR	________	EYE EXAM	________
MAMMOGRAM:	________	BREAST EXAM	________	STOOL CK FOR BLOOD	________
COLONOSCOPY:	________	PROSTATE EXAM	________	CHOLESTEROL CK:	________

FAMILY HISTORY

HAS ANY MEMBER OF THE FAMILY (INCLUDING PARENTS AND SIBLINGS) EVER HAD THE FOLLOWING?

ILLNESS	WHICH FAMILY MEMBER(S)?	AGE DIAGNOSED
CANCER (DESCRIBE WHICH TYPE)		
HYPERTENSION (HIGH BLOOD PRESSURE)		
HEART DISEASE		
DIABETES		
STROKE		
MENTAL DISEASE(ANIETY,DEPRESSION ETC)		
DRUG OR ALCOHOL ADDICTION		
GLAUCOMA		
BLEEDING DISEASE		
OTHER		

REVIEW OF SYSTEMS

DO YOU HAVE FREQUENT HEADACHES?	YES____	NO____
DO YOU DIFFICULTY HEARING?	YES____	NO____
DO YOU HAVE TROUBLE SWALLOWING?	YES____	NO____
HAVE YOU HAD ANY UNINTENTIONAL WEIGHT LOSS?	YES____	NO____
DO YOU HAVE DIFFICULTY BREATHING?	YES____	NO____
DO YOU HAVE FREQUENT CHEST PAIN?	YES____	NO____
DO YOU SUFFER FROM FREQUENT ABDOMINAL PAIN?	YES____	NO____
DO YOU HAVE FREQUENT DIARRHEA?	YES____	NO____
ARE YOU FREQUENTLY CONSTIPATED?	YES____	NO____
DO YOU SUFFER FROM SEXUAL DYSFUNCTION?	YES____	NO____
DO YOU HAVE TROUBLE URINATING?	YES____	NO____
ARE YOU HAVING TROUBLE WALKING?	YES____	NO____
DO YOU HAVE FREQUENT BACK PAIN?	YES____	NO____

PLEASE ELABORATE ON ANY OF THE ABOVE ANSWERS:

DOCTOR: ______________________________________

(PRINT NAME)

______________________________________ ____________