Front | Back

Today's Date:_____

Name: _____ DOB:_____

Current Address:_____

CITY/STATE/ZIP

Phone Number:_____

Email: _____

Main Complaint/Reason for Visit:

What is the reason for your visit?_____

When did this happen or first start?_____

If this occurred at work, please advise the front desk

Past Medical History-	(Circle)				
High Blood Pressure	Yes	No	Liver Disease	Yes	No
Heart Attack	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Stomach Ulcers	Yes	No
Other Medical Problems:					

Past Surgical History-	(Circle)				
Hysterectomy	Yes	No	Back or Spine	Yes	No
Gall Bladder	Yes	No	Tonsils	Yes	No
Appendix	Yes	No	Adenoids	Yes	No
Other Sugeries? Specify:					

Family History- Has anyone in your family (mom/dad/brothers/sisters) suffered from:				
Heart Attacks	Yes	No	At what age?	Who?
Strokes	Yes	No	At what age?	Who?
Cancer	Yes	No	At what age?	Who?
Social Habits				
Do you smoke?	Yes	No	How many packs per day?	
Do you drink alcohol?	Yes	No	How often do you drink?	

Any Allergies to medications_____

(Continued on back)

Front | Back

Current Medication and Dosage:_____

Vitamins or Herbal supplements:_____

Last Tetanus:_____

Date of Last Menstrual Period:_____

Pain Intensity Scale (Enter this number in the column)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

Who referred you to our clinic today?_____

Who is your medical doctor?_____

What is the Name and Location of the Pharmacy you will be using today?_____