PERSONAL INFORMATION - HEALTH HISTORY

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NAME ______________________ **Birthdate**:______________ Social Security no.______________

MAILING ADDRESS______________________________CITY__________________ZIP___________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ CHILD

PHONES: Work:________________ Home:______________ FAX:__________________

Cell: ________________ pager:______________ email:__________________

OCCUPATION:______________ **EMPLOYER** & address_____________________________

Spouse's **NAME**__________________ **EMPLOYER** & address_____________________________

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME__________________________

Their Social Security No.:________________ Birthdate:__________________________

Mailing Address:______________________________ Daytime Phone______________

HOW OR WHO **REFERRED** YOU TO OUR OFFICE?____

HEALTH HISTORY (please check if you have or had any of the following:)

☐ Yes ☐ No Are you in good health?

☐ Yes ☐ No Has your health changed in the last year

☐ Yes ☐ No Chest pain, shortness of breath

☐ Yes ☐ No Bleeding problems, bruise easily

☐ Yes ☐ No Headaches, ringing in ears

☐ Yes ☐ No Joint pain or stiffness, arthritis

☐ Yes ☐ No Fainting or seizures

☐ Yes ☐ No Heart disease, murmurs, rheumatic fever, prosthetic heart valve

☐ Yes ☐ No Pacemaker

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Hepatitis or liver disease

☐ Yes ☐ No TB, asthma or lung disease

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Cancer, Tumors

☐ Yes ☐ No Radiation treatment

☐ Yes ☐ No Psychiatric care

☐ Yes ☐ No Kidney or bladder disease

☐ Yes ☐ No VD, herpes

☐ Yes ☐ No HIV positive, AIDS, ARC

☐ Yes ☐ No Pregnant: month due__________

☐ Yes ☐ No Birth control Pills

☐ Yes ☐ No Recreational drugs

☐ Yes ☐ No Smoking / alcohol use

☐ Yes ☐ No Stroke

☐ Yes ☐ No Thyroid problem

☐ Yes ☐ No Other____________________

List any and all **ALLERGIES:**____

List any and all **DRUGS/MEDICATIONS** you are taking:______________________________

List any and all **SURGERIES:**____

☐ Yes ☐ No Are you being treated by a Doctor now? Who?______________________________

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: ______________________________ DATE:________________

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