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Patient Information and Profile

Name: _____ DOB: _____ Age: ___ Race: ___ Preferred Language: _____

Marital Status: Single: ___ Married: ___ Widowed: ___ Divorced: ___ Ethnicity: ___ Hispanic: ___ Not Hispanic

Females Only: Are you pregnant? Yes: ___ No: ___ If "No", Date of last menstrual period: ___/___/___

Do you have a Primary Physician? Yes: ___ No: ___ If "Yes", what is his/her name? _____

Who referred you to our office? (Doctor, Patient, or a Friend) _____

Reason for today's visit: _____

Is your problem due to an accident? Yes: ___ No: ___ If "Yes", what is the date of injury? ___/___/___

Where did your injury occur? _____ How did your injury occur? _____

Do you have drug allergies? Yes: ___ No: ___ If "Yes", please list drug and reaction: _____

Are you allergic to Betadine, Adhesive Tape, Xylocaine, or Latex? (If yes, please circle those that apply)

Have you ever experienced any complications with anesthesia? Yes: ___ No: ___

If "Yes", please explain: _____

Are you currently taking blood thinners (Coumadin, Plavix, Aspirin, etc.)? _____

List **all** medications that you are currently taking. Please also include **all** over the counter medications:
(If you have a separate list of medications, attach it to this form and write "see list" below)

- 1. _____ 2. _____ 3. _____ 4. _____
- 5. _____ 6. _____ 7. _____ 8. _____

Please list pharmacy name, phone number, and zip code: _____

Please list previous surgeries and approximate dates of these procedures:

- 1. _____ Date: ___/___/___
- 2. _____ Date: ___/___/___
- 3. _____ Date: ___/___/___
- 4. _____ Date: ___/___/___
- 5. _____ Date: ___/___/___

List any medical conditions affecting your immediate family:

1. _____
2. _____
3. _____
4. _____

Relation: _____
Relation: _____
Relation: _____
Relation: _____

Do you currently smoke tobacco? _____; Use smokeless tobacco? _____ Packs per day? _____ # of years? _____

Date of your last colonoscopy? _____ Date of your last pneumonia vaccine? _____

Do you have an advanced directive? _____

Do you consume alcoholic beverages? _____ On average, how many drinks do you consume per day? _____

GENERAL MEDICAL HISTORY

CARDIOVASCULAR

- Heart Attack
- Heart or Chest Pain
- Heart Disease
- High Blood Pressure
- Mitral Valve Prolapse
- Atrial Fibrillation
- Heart Bypass
- Bleeding Disorder
- Blood Clots
- Hypercholesterolemia

ENDOCRINE

- Diabetes (Type I/ Type II)
- Thyroid Disorders

EYE-EAR-NOSE-THROAT

- Bleeding Gums
- Glaucoma
- Ringing in Ears
- Visual Change

GASTROINTESTINAL

- Acid Reflux
- GI Ulcers or Bleeding
- Jaundice/Hepatitis
- Liver Disease
- Nausea or Vomiting

GENERAL

- Cancer
- Fever or Chills
- Glasses or Contacts
- Lumps or Masses
- Night Sweats
- Sleep Disorder
- Vertigo
- Weight Change

GENITOURINARY

- Incontinence
- Kidney Failure
- Urinary Tract Infection
- Venereal Disease
- Urinary Frequency

MUSCULOSKELETAL

- Backache
- Gout
- Joint Pain
- Joint Swelling
- Lupus
- Sciatica
- Neuropathy
- Osteoarthritis
- Osteoporosis
- Fibromyalgia
- Rheumatoid Arthritis

NEUROLOGIC

- Numbness
- Paralysis
- Seizures
- Stroke
- Weakness
- Headaches
- Cerebral Palsy

PSYCHOLOGICAL

- Anxiety
- Bipolar Depression
- Depression

RESPIRATORY

- Asthma
- Chronic Bronchitis
- Emphysema/COPD
- Pleurisy/Pneumonia
- Shortness of Breath
- Tuberculosis
- Sleep Apnea

****Do you currently have a pacemaker?** Yes No

EMAIL address _____

Signature of Patient or Guardian: _____ **Date:** ___/___/___