***Please print and complete everything

MR# _____

Patient Demographic Information

Patient's Name: _____

Date of Birth: _____/_____/_____ SSN:_____-_____-_____

Gender: Male Female Marital Status (S / M / W / D)

Home Number: (_____)_____-_____ Email Address: _____

Work Number: (_____)_____-_____ Patient Employer: _____

Cell Number: (_____)_____-_____ Referred By: _____

Contact Preference (for appointment reminders, Lab / Radiology Results):

_____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____ Patient Portal

Local Address:

_____
Street Apt #

_____
City State Zip

Permanent Address:

_____
Street Apt #

_____
City State Zip

Primary Insurance

Insurance Co. Name: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____-_____-_____

Policy Holder's DOB: _____/_____/_____

Secondary Insurance

Insurance Co. Name :_____

Policy Holder's Name: _____

Policy Holder's SSN: _____-_____-_____

Policy Holder's DOB: _____/_____/_____

Emergency Contacts:

#1 Name: _____ Phone: (_____)_____-_____

Relationship to you (circle one): Next of Kin Guardian Emergency Contact

#2 Name: _____ Phone: (_____)_____-_____

Relationship to you (circle one): Next of Kin Guardian Emergency Contact

We will call you or leave messages on your voicemail or via text message regarding upcoming appointments.
If you would NOT like this courtesy, please check NO: _____

May we leave messages regarding test results and follow-up appointments on your voicemail?

YES: _____ NO: _____

I have received a copy of the Privacy Policy from this provider and authorize the above list of person to receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Patient Signature: _____ Date: _____

Advance Directives; Living Will and/or Medical Power of Attorney:

_____ I have an Advance Directive and would like to provide a copy for my medical record.

_____ I do NOT have an Advance Directive, and do not want one at this time.

_____ I do NOT have an Advanced Directive, but would like one (please see receiptionist).

***Please print and complete everything

MR# _____

MEDICATIONS: What medications are you currently taking (Include prescription drugs and over the counter drugs)

Medication	Dose	Reason for Use	When Started

What vitamins/minerals/herbal supplements are you currently taking?

Brand	Dose	Reason for Use	When Started

PHARMACY: Please indicate your preferred pharmacy, including the telephone and address, that you would like us to send your prescriptions to.

Pharmacy Name: _____

Address: _____

Phone Number: _____

ALLERGIES: Please list drugs & type of reaction

Drug	Reaction

SURGICAL PROCEDURES: Please list type of surgery and date of surgery

Surgery	Date

***Please print and complete everything

MR# _____

PERSONAL MEDICAL HISTORY:

Please check the following conditions that apply to you and appropriate choices when given.

Past Condition	Ongoing Condition	
☐	☐	Alcoholism or Substance Abuse
☐	☐	Anemia
☐	☐	Arthritis (Please circle: Osteo or Rheum)
☐	☐	Blood Clots
☐	☐	Cancer (Type _____)
☐	☐	Chemotherapy
☐	☐	COPD
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Digestive (Crohn's, IBS, Ulcerative Colitis)
☐	☐	Ear/Hearing Problems
☐	☐	Easy Bleeding/Bruising
☐	☐	Fibromyalgia
☐	☐	Frequent Sinusitis
☐	☐	Gall Bladder Problems
☐	☐	GERD
☐	☐	Hay Fever, Allergies, Eczema
☐	☐	Hepatitis
☐	☐	Heart Attack, Heart Disease, Heart Failure
☐	☐	Heart Murmur
☐	☐	Headaches (Migraines, Tension)
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	History of Infertility
☐	☐	Insomnia
☐	☐	Kidney Infections/Stones
☐	☐	Motor or Vehicle Accident (Date: _____)
☐	☐	Neurologic (Specify: _____)
☐	☐	Organ Transplant
☐	☐	Osteoporosis
☐	☐	Pneumonia
☐	☐	Prostate
☐	☐	Rheumatic Fever
☐	☐	Seizures, Epilepsy
☐	☐	Serious Injury/Accident (Type: _____)
☐	☐	Sexually Trasmitted Disease (Chlamydia, Warts, Herpes) (Specify Other: _____)
☐	☐	Skin Disease (Specify: _____)
☐	☐	Sports Injuries (Types: _____)
☐	☐	Stroke
☐	☐	Thyroid Disease (Specify: _____)
☐	☐	Tuberculosis (TB)
☐	☐	Urinary Problems (Incontinence, Infections)
☐	☐	Vision Problems/Eye
☐	☐	Other (Specify: _____)

WOMEN ONLY:

Date of last menstrual period _____ Usual Flow: _____ Heavy _____ Moderate _____ Light

Do you have: ☐ Painful Periods ☐ Missed Periods ☐ Spotting between Periods
☐ Unusual Discharge/Infections ☐ Fibroids ☐ Endometriosis

Date of last Pap smear _____ History of Adnormal Pap smears? _____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Contraceptive History (Please check)

Birth Control Pills Type _____ Duration _____

IUD Type _____ Duration _____

Problems with current method _____

MEN ONLY:

☐ Prostate Problems ☐ Vasectomy ☐ Difficulty starting or stopping urination

☐ Change in Sexual Function (libido, energy, erections?) ☐ Testicular Cancer ☐ Painful urination or erection

Other concerns to discuss: _____

***Please print and complete everything

MR# _____

REVIEW OF SYSTEMS: Please check any of the following symptoms that apply to you.

General		Muscles/Bones/Joints	
Fatigue		Muscle pain	
Difficulty sleeping		Muscle cramps or spasms	
Weight loss or weight gain		Joint pain/stiffness/swelling	
Eyes/Ears/Nose/Throat/Sinuses		Low back pain	
Blurred vision		Neck pain	
Hearing loss or ringing in ears		Other:	
Frequent infections		Nervous System	
Jaw pain/TMJ		Headaches	
Frequent throat clearing or post-nasal drainage		Dizziness	
Heart/Circulation		Balance problems	
Chest discomfort (pain/pressure/tightness)		Weakness/Numbness/tingling	
Palpitations		Difficulty concentrating	
Leg swelling		Memory problems	
Lungs		Allergies/Immune System	
Shortness of breath		Seasonal allergies	
Wheezing		Food allergies	
Cough		Fever	
Coughing up blood		Other:	
Digestion/Elimination		Hormonal/Endocrine	
Heartburn/Reflux		Cold or heat intolerance	
Nausea/Vomiting		Night sweats	
Abdominal bloating		Excessive thirst	
Abdominal pain/cramping		Excessive hunger	
Excessive belching or gas		Blood	
Constipation		Easy bruising	
Diarrhea		Abnormal bleeding	
Kidneys/Bladder/Urination		Skin	
Urgency or increased frequency		Rashes	
Pain or burning with urination		Eczema	
Difficulty urinating		Psychiatric/Psychological	
Blood in urine		Depression	
Leakage		Anxiety or panic attacks	
Frequent infections		Suicidal thoughts	

***Please print and complete everything

MR# _____

FAMILY HISTORY Has anyone in your family ever had any of the following conditions?

Your Mother's Age: _____ Your Father's Age: _____

If deceased, cause of death: _____ If deceased, cause of death: _____

		List family members who have or had this illness
Arthritis		
Alcoholism or Substance Abuse		
Cancer: Breast		
Cancer: Colon		
Cancer: Other		
Depression or other Mental illness		
Diabetes		
Glaucoma		
High Blood Pressure		
Heart Disease		
High Cholesterol		
Kidney Disease		
Liver Disease (Hepatitis, etc.)		
Lung Disease (Asthma, COPD, etc.)		
Stroke		
Thyroid Disease		
Other:		

MIND/BODY

Are you sexually active? ☐ Yes ☐ No # of partners in the past year _____

Do you wish to be checked for STDs? ☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No # of packs/day _____

Do you smoke now? ☐ Yes ☐ No #of packs/day _____

Do you use recreational drugs? ☐ Yes ☐ No Types?_____ # time/week _____

How much alcohol do you drink per week? # drinks/week _____

How much caffeine do you drink per day? #drinks/day _____

How often do you exercise? # times/week _____

LIFESTYLE

With whom do you live? _____

What pets do you live with? _____

What are the ages of your children? _____

DIET and NUTRITION

How would you currently rate your healthy eating habits? ☐ Poor ☐ Fair ☐ OK ☐ Good ☐ Great

Are you currently on a special diet? _____

Do you have any sensetivities to food or avoid any food? _____

_____