Name: _____ Sex: _____ Age: _____ Today's Date: _____

Height: _____ft. _____in. Weight: _____lbs. Recent weight change? ☐ gain ☐ loss ☐ none Are you ? ☐ right-handed ☐ left-handed

WHAT PROBLEM ARE YOU BEING TREATED FOR TODAY? _____

Have you been treated by another physician for this problem? ☐ yes ☐ no Who? _____

Were x-rays taken? ☐ yes ☐ no Where were x-rays done? _____ When? _____

PAST MEDICAL HISTORY

Medical Illnesses *(check any illness that you currently have or have had in the past)*

☐ arthritis	☐ diabetes	☐ neuropathy	☐ ulcer disease
☐ asthma	☐ glaucoma	☐ rheumatoid disease	☐ vascular disease
☐ bleeding disorder	☐ heart disease	☐ seizure	☐ others
☐ blood clots	☐ hepatitis	☐ stroke	_____
☐ cancer	☐ high blood pressure	☐ substance abuse	_____
☐ cataract	☐ kidney/bladder problem	☐ thyroid	_____

Past Surgeries *(list type and year performed)*

_____ _____

_____ _____

Your Allergies to Medications *(name medication and reaction)* _____

Your Current Medications *(name of medication, dose and how often)*

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

Mother: ☐ living ☐ deceased Age (now or at death) _____ Cause of death: _____

Father: ☐ living ☐ deceased Age (now or at death) _____ Cause of death: _____

Has any blood relative had any of the following *(please check and indicate relationship, i.e. mother, father, sister, brother, etc.)*

☐ anesthesia problem	☐ cancer	☐ kidney disease	☐ other
☐ arthritis	☐ diabetes	☐ seizures	_____
☐ asthma	☐ heart disease	☐ stroke	_____
☐ bleeding disorder	☐ high blood pressure	☐ tuberculosis	_____

SOCIAL HISTORY

☐ single ☐ married ☐ widowed ☐ separated ☐ divorced # of children _____ and their present health status: _____

Your present occupation: _____

Do you drink alcohol? ☐ yes ☐ no Do you smoke? ☐ yes ☐ no Packs per day _____ # of years _____
Do you use recreational drugs? ☐ yes ☐ no

Patient Signature: **Date:** Dr's Initials: Date:

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1. ☐ Yes ☐ No Comments: _____
Patient Signature: _____ Date: _____ Dr's Initials: _____ Date: _____

2. ☐ Yes ☐ No Comments: _____
Patient Signature: _____ Date: _____ Dr's Initials: _____ Date: _____

3. ☐ Yes ☐ No Comments: _____
Patient Signature: _____ Date: _____ Dr's Initials: _____ Date: _____