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Please complete this entire packet and mail back or bring with you to your scheduled appointment.

Name_____**DOB**_____**Date**_____
Please list the full name & contact number of all physicians/specialists whom you are currently under the care of:

Previous physician or referring physician: _____
Previous physician phone _____ **Address**_____

Marital Status: Single □ Married □ Widowed □ Divorced □

With whom do you currently live with? _____

Are you currently working? Yes □ No □ **What is your occupation**: _____
Hand dominance: Right-handed □ Left-handed □ ambidextrous □
Please check if you are: Blind □ Deaf □ Hard of Hearing □
Please check if you use the following: Glasses □ Contacts □ Dentures □ Hearing Aid □ Walker □
Cane □ Wheelchair □ Brace □

Please list any surgeries you have had and the date:

Have you ever had any complications with anesthesia? If yes, please describe:_____

Please list your diagnosis (medical conditions) both mental and physical given to you by a medical professional:

List your current medical problems, including any substance addiction or abuse:

Date of last Tetanus Shot: _____ **Flu Shot**_____ **Pneumonia Shot**_____ **PPD**_____
(Please bring shot records or have them faxed to our office prior to your visit).

Date of last Pap Smear_____ **Menstrual Cycle**_____ **Mammogram**_____
Colonoscopy_____ **Bone Density Scan**_____ **Name of your OB/GYN**:_____
Do you have any children? _____If so, how many? _____

Family History

	Living or Deceased	Please list any health problems, diagnosis, mental problems or substance abuse for each.
Mother		
Father		
Brother1		
Brother 2		
Brother 3		
Sister 1		
Sister 2		
Sister 3		

Please include any other pertinent family medical history

_____
_____
_____

On average, how many hours of sleep do you get per night? _____ **Do you have trouble sleeping? Please explain**:

_____

Do you smoke? _____**If so, how many packs per day**? _____**Did you ever smoke**? _____ **If so, how long_____ When did you quit**? _____ **Never smoked**_____

Do you drink alcohol? _____ **Please specify type**_____ **If so, how many per month**? _____

Do you consume caffeine? _____**Please specify type** _____**How many cups per day**?

_____

How often do you exercise? Never □ Rarely □ Sporadic □ Regularly □

Do you have any tattoos? _____Please list locations: _____

Do you have any piercings? _____Please list locations: _____

What is your sun exposure? Minimum □ Moderate □ Excessive □ Do you wear sunscreen? _____SPF_____

Name_____DOB_____Date_____

Please list all medications you are currently taking, including vitamins and herbal supplements

Name	Dosage (mg, mcg, %, etc.)	Directions (daily, twice a day, weekly, etc..)

If you need more room please use the back of the page.

****Please bring all of you medication bottles with you to your appointment.**

Do you have any allergies to medications? Please list and specify your reaction

Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____

*****Please bring the following advance directives if you have them: Health Care Proxy, Do not Resuscitate Order, Do not Intubate Order, Living Will.**

******Please arrive 15 minutes early to your scheduled appointment to allow us time to review your paperwork. Thank You**

Name_____DOB_____Date_____

Please <u>circle</u> if you are <u>currently</u> experiencing any of the following:

Skin rashes, changes in any moles or skin lesions

Headaches, dizziness, fainting

Eye problems/discomfort, double or blurred vision

Bloody nose, nasal discharge

Neck pain, stiffness, swelling, limitation in motion

Chest cold, clearing throat, dry cough, coughing up blood, chills, fever, night sweats

Shortness of breath, rapid or irregular heartbeat, ankle/leg swelling, wheezing

Open sores on feet/legs, pain/discomfort in the legs, chronic cold feet,
blue discoloration of feet/toes

Increased appetite/loss of appetite, difficulty swallowing, vomiting blood, unusual belching or gas from rectum, change in bowel habits or color, weight loss, heartburn

Yellow skin/eyes, constipation, diarrhea, pain with bowel movements, rectal bleeding, hemorrhoids, increased urination, painful urination, blood in urine, nighttime urination, hesitancy, dribbling

Abnormal periods, heavy bleeding, painful cramping, spotting between periods,
vaginal discharge

Easy bruising, swollen or enlarged lymph nodes, anemia

Unusual increase in urination, weight gain/loss, unusual sweating, chronic fatigue, hair loss, increased thirst, severe dry skin

Joint pain, joint swelling, muscle pain, muscle swelling, joint/muscle stiffness/cramping

Confusion, decreased memory, unable to concentrate, difficulty speaking, difficulty walking, loss of bladder control or bowels, numbness or tingling in arms/legs