

PATIENT PROFILE

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK _____ CELL _____

AGE _____ DATE OF BIRTH _____ BIRTHPLACE _____

SOCIAL SECURITY NUMBER (Responsible Party) _____ - _____ - _____

OCCUPATION _____

EMPLOYER'S NAME AND ADDRESS: _____

REFERRED BY _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME _____ HOME PHONE _____

WORK PHONE _____

LIST HEALTH PROBLEMS/COMPLAINTS IN ORDER OF IMPORTANCE.

1) _____ 3) _____

2) _____ 4) _____

IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF YOUR EMPLOYMENT _____

HAVE YOU HAD THE SAME OR SIMILAR SYMPTOMS BEFORE? _____ IF SO, WHEN? _____

HAVE YOU SEEN A PHYSICIAN FOR THE ABOVE CONDITIONS? _____ IF SO, WHO AND WHEN? _____

DATE OF YOUR LAST COMPLETE PHYSICAL EXAM _____

MEDICAL HISTORY:

CURRENT MEDICATIONS: _____

NUTRITIONAL SUPPLEMENTS, HERBS: _____

SERIOUS ILLNESSES: _____

MAJOR ACCIDENTS: _____

INDICATE APPROXIMATE AMOUNTS BELOW:

	NEVER	OCCASSIONALLY	WEEKLY	DAILY
COFFEE	_____	_____	_____	_____
TOBACCO	_____	_____	_____	_____
ALCOHOL	_____	_____	_____	_____
DRUGS (RECREATIONAL)	_____	_____	_____	_____
ASPIRIN	_____	_____	_____	_____
SUPPLEMENTS	_____	_____	_____	_____
ANTACIDS	_____	_____	_____	_____

DO YOU USE A SPECIAL DIET? _____

DO YOU REACT TO CERTAIN FOODS, POLLENS OR ANIMALS? IF SO LIST THEM BELOW:

- 1) _____ 2) _____
3) _____ 4) _____

LIST ANY CHEMICALS, METALS, DUSTS OR FUMES YOU ARE EXPOSED TO REGULARLY AND HOW YOU REACT TO THEM: _____

HOW FREQUENTLY HAVE YOU TAKEN ANTIBIOTICS? _____

FAMILY HISTORY (PLEASE INDICATE IF ANY AND WHICH FAMILY MEMBERS HAVE HAD ANY OF THE FOLLOWING CONDITION(S).

- 1) _____ ALLERGIES 8) _____ THYROID DISORDER
2) _____ ALCOHOLISM 9) _____ HIGH BLOOD PRESSURE
3) _____ ASTHMA 10) _____ HYPOGLYCEMIA
4) _____ CANCER 11) _____ KIDNEY DISEASE
5) _____ DIABETES 12) _____ NERVOUS OR MENTAL DISORDER
6) _____ EPILEPSY 13) _____ TUBERCULOSIS
7) _____ HEART DISEASE 14) _____ OTHER INHERITABLE CONDITION

HAVE YOU HAD ANY OF THE ABOVE? _____ WHICH? _____

YOUR HEALTH HISTORY (PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING)

- | | | | |
|----------|------------------------|-----------|-------------------|
| 1) _____ | BACK TROUBLE | 8) _____ | LOSS OF SEX DRIVE |
| 2) _____ | CATARACTS | 9) _____ | RHEUMATIC FEVER |
| 3) _____ | GALL BLADDER DISORDER | 10) _____ | SCARLET FEVER |
| 4) _____ | COLITIS/DIVERTICULITIS | 11) _____ | SKIN PROBLEMS |
| 5) _____ | INSOMNIA | 12) _____ | HEARING LOSS |
| 6) _____ | LIVER DISEASE | 13) _____ | VISUAL DISORDER |
| 7) _____ | VENEREAL DISEASE | 14) _____ | CANCER |

(GONORRHEA, SYPHILIS, HERPES, WARTS ETC.)

WOMEN:

MENSTRUAL CYCLE REGULAR? _____ LENGTH OF CYCLE? _____

ARE YOU PREGNANT? _____ NUMBER OF PREGNANCIES? _____ BIRTHS? _____

MISCARRIAGES? _____ ABORTIONS? _____

HAVE YOU EVER USED BIRTH CONTROL PILLS? _____ DATES? _____

WHEN WAS YOUR LAST PAP SMEAR? _____ RESULTS? _____

DO YOU EXPERIENCE PREMENSTRUAL SYMPTOMS? _____

WHAT ARE THEY AND HOW SEVERE? _____

HISTORY OF VACCINATIONS (FOR CHILDREN ONLY):

I UNDERSTAND THAT MY INSURANCE COMPANY MAY NOT REIMBURSE FOR THE EXPENSES INCURRED AT THIS OFFICE. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL DEBT.

PERSON PAYING FOR THE BILL (if not patient) _____

SIGNATURE

DATE

