Please Fill Form and Print

Welcome to Our Office

Use Black Ink

Last Name: First Name: Middle Initial:

Birth Date: / / Age: Marital Status: Gender:

Address: City: State:

Home Phone: ( ) - Cell Phone: ( ) - Zip:

Work Phone: ( ) - Employer:

Social Security #: - - Occupation:

Email Address:

Emergency Contact: Relationship:

Parent or Gardian's Name (if minor): Phone #: ( ) -

Medical Insurance: Carrier Name:

Policy #: Subscriber Name:

Group #: Subscriber Birth Date: / /

Secondary Insurance: Carrier Name:

Policy #: Subscriber Name:

Group #: Subscriber Birth Date: / /

Medical History

Family Physician:

Did anyone refer you to us? Who?

What problem brings you in today?

Shoe Size: Height: Weight: **Lbs**

Past Medical History ✔ *(**Check** all that apply):*

- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Bleeding Problem**
- ☐ **Blood Clot**
- ☐ **Cancer**
- ☐ **Cholesterol**
- ☐ **Circulation Problem**
- ☐ **Diabetes**
- ☐ **Gout**
- ☐ **Headaches**
- ☐ **Hearing Problems**
- ☐ **Heart Attack**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **HIV Positive**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Lung Disease / Asthma**
- ☐ **Peptic Ulcer / Acid Reflux**
- ☐ **Stroke**
- ☐ **Thyroid**
- ☐ **Vision Problem**
- ☐ **Other:**

List all medications you take:

List all allergies you have:

Do You Smoke? How Much? Time(s) per

Do You Drink? How Much? Time(s) per

List all operations or serious injuries you have had:

Does anyone in your family have? ✔ *(**Check** all that apply):*

- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Heart Trouble**
- ☐ **High Blood Pressure**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Stroke**

For Women Only : Are You Pregnant? How many months?

Patient Signature: Date: