Patient Name: _____ Date: _____

Date of Birth: _____

MEDICAL HISTORY AND REVIEW OF SYSTEMS

PLEASE CHECK IF YOU HAVE ANY OF THE CURRENT PROBLEMS

☐	Sleep Apnea	☐	Gallbladder Disease
☐	Diabetes	☐	Kidney Disease
☐	Cancer	☐	Difficulty Urinating
☐	Heart Disease	☐	Colitis
☐	Chest Pain	☐	Changes in Bowel habits
☐	Heart murmur	☐	Indigestion
☐	Shortness of Breath	☐	Nausea
☐	Swollen Ankles	☐	Vomiting
☐	Palpitations	☐	Constipation
☐	Lightheadedness	☐	Diarrhea
☐	High Blood Pressure	☐	Blood in Stool
☐	High Cholesterol	☐	Ulcers
☐	Asthma	☐	Abdominal Pain
☐	Bronchitis	☐	Hemorrhoids
☐	Pneumonia	☐	Hepatitis
☐	Thyroid Disease	☐	Alcohol Abuse
☐	Ear , Nose Throat problems	☐	Drug Abuse
☐	Seasonal Allergies	☐	Spine Disc Bulge or Herniation
☐	Seizures	☐	Osteoarthritis/Rheumatoid
☐	Headache	☐	Autoimmune disorders
☐	Vision problems	☐	Fractures
☐	Neurological disorders	☐	HIV/Aids STD
☐	Blood Disorder	☐	Anxiety
☐	Skin Disorder	☐	Depression

PLEASE LIST AND SUPPLY THE DATES OF SURGERIES:

_____

_____

_____

_____

CURRENT MEDICATIONS (Prescriptions, Over-the Counter, Vitamins, Herbs, Etc.)

_____

_____

_____

_____

_____

ALLERGIES:

_____

_____

_____

FAMILY HISTORY

Has any member of your family (first degree relatives including parents, grandparents and siblings) ever had the following?

	Which Family Member?
Cancer (describe the type)	
Hypertension (high Blood Pressure)	
Heart Disease	
Diabetes	
Strokes	
Bleeding Diseases	
Arthritis	

DAILY HABITS:

Smoke:	Packs Daily
	How Long
Exercise Routine:	

Coffee:	Cups Daily
	Other Caffeine
Alcohol:	Type
	Amount
Sleep:	Difficulty Falling Asleep
	Continuity Disturbances
	Snoring

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I have provided the below listed contact information and understand that I may update this information to include or exclude any of the contacts effective immediately.

Name: _____ Birthdate: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Please indicate if this office is allows to leave messages (examples: appointment reminders or changes, message to call office, authorizations received, etc…) for you on your:

- Home phone _____
- Work phone _____
- Cell Phone _____
- Other _____

Please list any/all person(s) your medical information may be released to or discussed with by phone or in person:

- Name:_____ Relationship: _____
- Phone: _____

- Name:_____ Relationship: _____
- Phone: _____

- Name:_____ Relationship: _____
- Phone: _____

- Name:_____ Relationship: _____
- Phone: _____

- Name:_____ Relationship: _____
- Phone: _____

- Name:_____ Relationship: _____
- Phone: _____

- Name:_____ Relationship: _____
- Phone: _____