Patient Information Sheet (Strictly Confidential)

Patient Name______________________________ Date________________

Birth Date________________ Age______ SS#________________________ Married____

Address__________________________ City ________________ Zip __________

Email______________________ Home phone______________ Cell ______________

Responsible Party____________________ Relationship ______________ Birth Date__________

Insurance Carrier(s)______________________________ Policy# ________________

Emergency Contact______________ Relationship ____________ phone#________________

Referring Doctor__________________ Reason for Visit ________________________

Medical History

Please circle any conditions you have currently, or have had in the past:

Abdominal pain	Diabetes	Kidney Failure	Shortness of breath
Arthritis	Diarrhea	Kidney Stones	Stroke
Asthma	Emphysema	Liver problems	Swelling ankles
Back pain/injury	Epilepsy	Lupus	Swallowing problems
Bleeding problem	Fevers	Migraines	Thyroid problems
Blood clots	Heart attack	Nausea	Tuberculosis
Breast lump/pain	Hemorrhoids	Pacemaker	Ulcers
Bronchitis	Hepatitis (type)________	Pneumonia	Varicose Veins
Cancer (type) ________	High Blood Press.	Poor Circulation	Vomiting
Chest pain	High Cholesterol	Poor Healing	Vomiting blood
Constipation	Insulin Resistance	Prostate Problem	Weight Gain
Cough	Irreg. Heart Rate	Rectal bleeding	Weight Loss

Medical Allergies____

Current Medications____

Surgeries____

Alcohol/Tobacco/Drug use and amount______________________________

Current Aspirin/Ibuprofen/Blood Thinner use?______________ **Currently pregnant?**_____ **STD history?**_____

Family History (circle any that apply)

Heart Disease	High Blood Pressure	Diabetes	Cancer____________
Stroke	Bleeding	Blood Clots	Anesthesia Problem

Other____

Signature________________________ (This form is complete and correct to the best of my knowledge)