PATIENT INFORMATION/MEDICAL HISTORY

Name:_____Date:_____Age:_____

Address:_____
Street

_____ _____ _____
City State Zip Code

Phone: Home:_____ Work:_____Cell:_____

Date of Birth:_____ Marital Status: S M D W Sex: F_____M _____

E-mail (used for receipts & special offers):_____

Employer:_____Occupation:_____

Emergency Contact:_____Relationship:_____

Phone: Home:_____Work:_____Cell:_____

Personal Physician:_____Office Number:_____

Referred by:_____

HEALTH HISTORY

Current Medications (Prescription, over the counter, vitamins, & herbal supplements)

_____Antibiotics
_____Anti-Coagulant ex: Asprin, Blood thinners Coumadin,Heparin
_____Calcium Channel Blockers
_____Anti-Inflammatory ex: Advil, Aleve, Ibuprofen, Motrin
_____Herbals & Vitamins ex: Fish Oil, Omega 3, Vit. E

Other Medications:

_____ _____

_____ _____

_____ _____

Allergies:_____Albumin____Latex ____Lidocaine _____Benzyl Alcohol (found in Bacteriostatic Saline)

Allergies to Other Medications:_____

_____

Surgeries/Dates:_____

Have a History of?

_____Asthma
_____Heart Disease
_____Diabetic _____Insulin _____Oral Meds_____ Diet Controlled
_____Mental Health (ex: Depression, Bipolar, Anxiety)
_____Neuro-Muscular Disease (ex: Lou Gehrig Disease/ALS, Lambert-Eaton Syndrome, Multiple Sclerosis, Myasthenia Gravis, Muscle weakness, Parkinsons. Guillain-Barre Syndrome,Bells Palsy)
_____Excessive Bleeding (Factor 7, 8, Hemophilia)
_____Auto-Immune Disorders (ex: AIDS, HIV, Rheumatoid Arthritis, Lupus)
_____ Cancer
_____Liver Disease (Hepatitis, Cirrhosis)
_____Thyroid Disorder/Hormone Therapy
_____Cold Sores/Fever Blisters
_____OB/GYN Problems
_____Respiratory Problems
_____Other

Weight:_____Height:_____

Are you? Pregnant:_____Nursing:_____

Do you Smoke:_____Amount per Day?_____

Do you Drink: _____Amount per Day?_____

REASON FOR VISIST OR AREAS OF CONCERNS:_____

The above information is true & accurate to the best of my knowledge.

Patient Signature **Date**

Registered Nurse **Date**

PA/Physician **Date**