Date: ______________________
Referred By: ______________________

Personal Information

(Please Fill Out Completely)

Dr./Mr./Mrs./Ms. ____Age_____
First *Middle* *Last*

Date of Birth: __________________ Check One: ☐ Single ☐ Married ☐ Divorced

Mailing Address: ____
Number and Street *City* *State* *Zip*

Home Phone: _______________________ Cell Phone: _______________________

Social Security #: _____________________ Email: ____________________________

Employer Information

Employer: ____ Phone: ______________________

Address: ____
Number & Street *City* *State* *Zip*

Occupation: ____

Family Information

Name of Spouse: ____
First *Middle* *Last*

Spouse Work Phone: __________________ Spouse Cell Phone: ___________________

Children: ________________________________ ________________________________
Name *Age* *Name* *Age*

________________________________ ________________________________
Name *Age* *Name* *Age*

Pets: ________________________________ ________________________________
Name *Type* *Age* *Name* *Type* *Age*

Emergency Information

Emergency Contact: ___________________________________ Phone: ________________

Relationship: ____________________________

History Questionnaire

Name: _________________________________ Date:__/__/___ Birthday__/__/___

How did you hear about our office? ___Internet ___Friend ___Social Media ___Sign ___Other____________

Referred by someone such as an Established Patient or Attorney? Name________________________________

Have you been treated by another doctor for your complaints? ___Yes ___No If yes please list below:

____

Have you received any of these tests? ___X-rays ___Lab Work ___MRI ___CT Scan Are you pregnant____

Please list any medications, vitamins or supplements you are taking: _____________________________

____

Have you ever been involved in an accident? ___Yes ___No If yes, please list the date and symptoms:

____

____

Have you ever had an operation or surgery? ___Yes ___No If yes, please list dates and procedures:

____

Have you had any major hospitalizations? ___Yes ___No If yes, please list dates and procedures:

____

Do you have any health problems we need to know about? ___Yes ___No Diabetes Cancer Heart Disease

Please describe: ____

____

Do you suffer from: __allergies __sinusitis __weight trouble __migraines __fatigue __bloating

Please explain: ____

____

Do you have a family history of illness we need to know about? ___Yes ___No Please list disease and which relative. ____

____

Have you lost any time from work because of these complaints? ___Yes __No If yes, please list the dates missed ____________________________________ Type of Employment: ________________________

Do you have any other types of employment? ____

<u>Please circle any symptoms you may have</u>

<u>General</u>: fever weight loss weight gain night sweats fatigue sleep loss appetite loss bumps/masses unexplained falls allergic reactions double vision blind spots floaters

<u>Thyroid Symptoms</u>: mood swings sweaty diarrhea tremors palpitations visual disturbances slow tired depressed thin hair croaky voice heavy periods constipation dry skin

<u>Neurological</u>: changes in (sight smell hearing taste) seizures fainting limb weakness poor balance speech problems

<u>Cardiovascular</u>: chest pain shortness of breath difficulty exercising palpitations faintness

<u>Ear Nose and Throat</u>: runny nose nose bleeds sinus pain stuffy ears ear pain ringing in ears bleeding gums toothaches sore throat pain swallowing

<u>Respiratory</u>: cough sputum wheezing

<u>Gastrointestinal</u>: abdominal pain difficulty swallowing indigestion bloating cramping nausea vomiting diarrhea constipation red blood in stool foul smelling stools dark black tarry stools

<u>Urinary</u>: irritation obstruction incontinence painful urination blood in urine excessive urination urination in sleep hesitancy dribbling decreased force of stream

<u>Genital/Vaginal</u>: discharge painful periods irregular periods heavy light menopause

<u>Psychiatric</u>: depression sleep patterns anxiety