PATIENT'S MEDICAL HISTORY

Date: ________ Name ______________________________ Male ________ Female ________ DOB ___________

Marital Status ___________ Race___________ Ethnicity (circle one): American African-American Asian Korean Hispanic Other_________

Primary Language Spoken_______________ Patient's Social Security # _______________________

Address____ City______________________ ST_______ ZIP__________

Home # ____________________ Cell # __________________ Emergency Contact + Phone ______________________

Parent/Guardian name ________________________________ Phone # ______________________________

Email Address _________________________________ Primary MD ________________________________

Preferred Pharmacy:___________________________ Pharmacy Location_____________________________

Detailed Reason for Visit Today ____ **Weight** _________ **Height**__________

Current Medical Issues: circle any current medical issues

Fever	Hearing Loss	Irregular Heart Beat	Painful Urination	Anxiety
Weight Gain / Obesity	Sore Throat	Chest Pain / Pressure	Pelvic Pain	Depression
Weight Loss	Sinus Congestion	Palpitations	Genital Lesion	Memory Loss
Eye Pain	Asthma	Diarrhea	Rash	Pregnant
Eye Discharge	Shortness of Breath	Constipation	Mole Change	Breast Feeding
Cough	Wheezing	Abdominal Pain	Cancer	

Medical History:

Please check if you have / had any of the following. Give date of ailment. Advise any ailments afflicting biological parents.

	Self	Mom / Dad				Self	Mom / Dad	
Heart Attack					Migraine			
Heart Disease					Diabetes (Type 1 or Type 2)			
Atrial fibrillation					Asthma			
COPD					Arthritis			
High Blood Pressure					Cancer - What kind?			
Gastroesophageal Reflux Disease					Other ______________			
Splenectomy					Other ______________			

List **ALL MEDICATIONS** you are currently taking, including prescription & over the counter. INCLUDE ASPIRIN, MOTRIN, IBUPROFEN & VITAMINS.

Drug	Dosage (if known)		Drug	Dosage (if known)

List **ALLERGIES TO MEDICATIONS**______________________________ **REACTIONS TO MEDICATIONS** ________________

List **ALLERGIES TO ENVIRONMENTAL FACTORS** ______________________ **REACTIONS** ______________________

Do you currently take **COUMADIN / PLAVIX/ASPIRIN?** ___________ If so, whom is the monitoring MD? ____________________

ALLERGIC TO LATEX _________ **ALLERGIC TO TAPE** __________ **ALLERGIC TO IODINE**__________

Surgical History:

Surgery	Date		Surgery	Date		Surgery	Date

Social History:

Do you smoke?		Drink alcohol?		Ever used illegal drugs?	
How often?		How Frequently?		Occupation?	

I, the undersigned, certify that I have answered the above questions truthfully to the best of my abilities.

____

Responsible Party Signature **Date**

Patient Insurance Information

Patient's Name________________________________ **Today's Date**_______________

Patient's Social Security #______________________ **Patient's DOB** ______________

1) **Primary Insurance**

   Name of Insurance Company______________________________
   Subscriber's Name ______________________________
   Subscriber's Date of Birth ______________________________
   Subscriber's Social Security #______________________________
   Is the subscriber's address the same as yours? _____ Yes _____ No
   If not, please print subscriber's address:

   ____

2) **Secondary Insurance**

   Name of Insurance Company______________________________
   Subscriber's Name ______________________________
   Subscriber's Date of Birth ______________________________
   Subscriber's Social Security #______________________________
   Is the subscriber's address the same as yours? _____ Yes _____ No
   If not, please print subscriber's address:

   ____

3) **Tertiary (third) Insurance**

   Name of Insurance Company______________________________
   Subscriber's Name ______________________________
   Subscriber's Date of Birth ______________________________
   Subscriber's Social Security #______________________________
   Is the subscriber's address the same as yours? _____ Yes _____ No
   If not, please print subscriber's address:

   ____