PERSONAL INFORMATION:

Patient Name: ____ Today's Date: ____________________

Home Address: ____City______________________ State_________ Zip Code:______________

Date Of Birth:________/__________/_________ E-Mail:____

Home#:_________________________Cell#:_________________________________ Work#:_________________________

Occupation____

Emergency Contact: (Name/Relationship) ____ Phone: ______________________________

Circle what applies:

Married Single Divorced Widowed Separated Partnered for ____ years

Date of last medical examination: __________________ How did you hear about us: ____

What is your concern today ____

Any Surgeries or treatments within the year____

What is your estimate of your general health: Excellent Good Fair Poor (Circle what applies)

Which do you use & how much?

Caffeine______________________ Tobacco____________________ Street Drugs _____________ Marijuana ___________Other________________

Are you exposed to any of these? ☐ Stress ☐ Heavy Lifting ☐Hazardous Substances ____

Are you allergic to or have you ever had an allergic reaction to any of the following? Circle all that apply

Aspirin Ibuprofen Acetaminophen Codeine Local Anesthetic Fluoride Latex Penicillin Erythromycin

Tetracycline Metals (Titanium Amalgam Stainless Steel Nickel) Adhesive

Any other allergies that are not listed?

____

Please list any Medications, Vitamins, Herbal or Dietary Supplements currently taking and what it is for:

____

____

____

____

MEDICAL/FAMILY HISTORY:

Mother: ☐ Alive ☐ Deceased ***Father*** ☐ Alive ☐ Deceased

Check illnesses which have occurred in any of your blood relatives and which relative it occurred

☐ Diabetes_____________________
☐ Stroke ______________________
☐ Cancer______________________
☐ Kidney Disease________________
☐ Tuberculosis _________________
☐ Auto Immune Disease______________
☐ Heart Disease_________________
☐ Mental Illness_________________
☐ High Blood Pressure____________

CONDITIONS YOU HAVE, HAD OR BEEN EXPOSED TO

☐ AIDS
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting ☐ Blood
- ☐ Stomach pain
- ☐ Rectal Bleeding

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-halos/flashing

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High/low blood pressure
- ☐ Irregular/rapid heart beat
- ☐ Poor Circulation
- ☐ Swelling of ankles
- ☐ Varicose Veins

SKIN

- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Changes in moles
- ☐ Scars
- ☐ Sore that won't heal

URINARY

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Painful Urination

MEN ONLY

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other_______________

WOMEN ONLY

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Other_______________
- ☐ Hysterectomy_________
- ☐ Date of last menstrual period______________
- ☐ Date of last pap smear_______________
- ☐ Date of last mammogram/ breast ultrasound/ thermography_____________
- ☐ Are you pregnant Yes No
  Number of children______

Insurance Policy

Because we do not take insurance we try to offer the most reasonable price compared to other clinics that offer similar services. The price is low enough for our patients when compared to the higher prices other offices charge, which makes it hard for our business to deduct or discount our services any further. We do not take insurance for any of our services, but we can process certain labs depending on the frequency and the reason. Please let us know you acknowledge and understand these circumstances ________ **INITIAL**

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_______________ __________________________________ ___________________________________

DATE **PRINT NAME** (Parent/Guardian) **SIGNATURE** (Parent/Guardian)