PATIENT'S MEDICAL INFORMATION FORM

Patient's
Full Name:_____(_____)
FIRST MIDDLE LAST NAME KNOWN BY

Age:_____ Birthdate:_____/ _____/_____ Occupation:_____
MO DAY YEAR

Referred by:_____ Relationship:_____

Address of person who referred you:_____

City:_____ State:_____ Zip Code:_____

Primary Care Physician:_____ Doctor's Phone: (____)_____

City:_____ State:_____ Zip Code:_____

Reason You Are Being Seen:_____ Date Problem Began:_____/ _____/_____
MO DAY YEAR

How did this injury happen? _____

Was this an accident? YES___NO___ Where were you? HOME___WORK____CAR____OTHER____

Have you ever been hospitalized for medical or surgical problems? YES___NO___

If yes, please describe, including date(s):_____

_____

Do you have any of the following?

High blood pressure? YES___NO___ Heart disease? YES___NO___

Vascular disease? YES___NO___ Diabetes? YES___NO___

Asthma / lung disease? YES___NO___ Gout? YES___NO___

Crohn's disease / ulcerative colitis? YES__NO___ Sleep Apnea? YES___NO___

Rheumatoid arthritis / lupus / other autoimmune disease? YES___NO___

Any other chronic illness? If so, what?_____

Do you smoke? YES___NO__ Do you drink? YES___NO__ Do you use drugs? YES___NO___

Do any of your **blood relatives** have any of the following (including deceased relatives)?

High blood pressure? YES___NO___ Heart disease? YES___NO___

Cancer or tumors? YES___NO___ Diabetes? YES___NO___

Any chronic illness(es)? If so, what?_____

Signature:_____Date:_____