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: (_____)_____

Physician's address:_____

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):_____

_____

Please describe any outpatient surgeries and dates you have had: _____

_____

Do you smoke? YES____NO____ Do you drink? YES____NO____ Do you use drugs? YES____NO____

Do you have any of the following?

High blood pressure? YES____NO____ Heart disease? YES____NO____

Vascular disease? YES____NO____ Diabetes? YES____NO____

Asthma / COPD / 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 any of your **blood relatives** have any of the following (including deceased relatives)?

____ Don't know because I am adopted.

High blood pressure? YES____NO____ Heart disease? YES____NO____

Cancer or tumors? YES____NO____ Diabetes? YES____NO____

Any other chronic illness? If so, what?_____

Signature:_____Date:_____