

Date: _____ - _____ - _____

PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____ / _____ / _____
Month Day Year

Sex: M F Race Caucasian ___ Afro-American ___ Oriental ___ Indian ___ Other _____

Family Doctor: _____ Referring Doctor: _____

Reason for visit / chief complaint _____

PAST MEDICAL HISTORY **None**

(Please circle all conditions that you have or have had)

| | | | |
|-------------------------------|-----------------------|-----------------------|--------------------------------|
| None | Bleeding Difficulties | Diabetes Mellitus | Asthma |
| Heart Disease | Hepatitis | Insulin Dependent | TB |
| High Blood Pressure | HIV | Oral Medication | Emphysema |
| Stroke | | Diet Controlled | Arthritis (Name or Type) _____ |
| Cancer (Type/Treatment) _____ | | Other (specify) _____ | |

PAST SURGICAL HISTORY **None**

| Type or Surgery | Year | Type or Surgery | Year |
|-----------------|-------|-----------------|-------|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

PRESCRIPTION MEDICATIONS **None**

| Medication | Dose/Number per day | Medication | Dose/Number per day |
|------------|---------------------|------------|---------------------|
| 1. _____ | _____ | 5. _____ | _____ |
| 2. _____ | _____ | 6. _____ | _____ |
| 3. _____ | _____ | 7. _____ | _____ |
| 4. _____ | _____ | 8. _____ | _____ |

NONPRESCRIPTION MEDICATIONS **None**

| Herbal Preparations | | Over-the counter Drugs/Vitamins | |
|---------------------|----------|---------------------------------|----------|
| 1. _____ | 4. _____ | 1. _____ | 4. _____ |
| 2. _____ | 5. _____ | 2. _____ | 5. _____ |
| 3. _____ | 6. _____ | 3. _____ | 6. _____ |