



Please circle Y (yes) or N (no) if you have, or have had a condition. Circle M (medications) if you are taking medications for the condition.

**General**

Good general health	Y	N	M
Recent weight changes	Y	N	M
Fatigue	Y	N	M
Night sweats/fevers	Y	N	M

**Cardiovascular**

Angina/chest pain	Y	N	M
Coronary artery disease	Y	N	M
Heart surgery	Y	N	M
Pacemaker/Defibrillator	Y	N	M

**Musculoskeletal**

Muscle pains or cramps	Y	N	M
Stiffness/swelling in joints	Y	N	M
Joint pain	Y	N	M
Osteoporosis	Y	N	M

**Endocrine**

Excessive thirst/urination	Y	N	M
Thyroid disease	Y	N	M
Hormone problem(s)	Y	N	M
Hearing loss/ringing in ears	Y	N	M
Sinus problems	Y	N	M
Nose bleeds	Y	N	M
Sore throat	Y	N	M
Voice changes	Y	N	M

**Respiratory**

Shortness of breath	Y	N	M
Excessive coughing	Y	N	M
Asthma	Y	N	M
Bronchitis	Y	N	M
Emphysema	Y	N	M

**Neurological**

Frequent headaches	Y	N	M
Seizures/Epilepsy	Y	N	M
Numbness/tingling	Y	N	M
Dizziness	Y	N	M
Weakness	Y	N	M
Stroke/TIA	Y	N	M

**Hematologic/Lymphatic**

Bruise easily	Y	N	M
Slow to heal	Y	N	M
Enlarged glands	Y	N	M
Glaucoma	Y	N	M

**Allergies**

Food	Y	N	M
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Medicine	Y	N	M
<b><u>Gastrointestinal</u></b>			
Nausea/Vomiting	Y	N	M
Abdominal pain	Y	N	M
Rectal pain	Y	N	M
Blood in urine	Y	N	M
Kidney stones	Y	N	M
<b><u>Other</u></b>			
Changes in hair or nails	Y	N	M
Rashes or Itching	Y	N	M
Breast lump	Y	N	M
Breast pain or discharge	Y	N	M
Change in menstrual cycle	Y	N	M
Tuberculosis	Y	N	M
Cancer	Y	N	M
Chemotherapy or radiation	Y	N	M
HIV/AIDS	Y	N	M
Diabetes	Y	N	M
Blood clots	Y	N	M
Depression	Y	N	M
Insomnia	Y	N	M
Confusion or memory loss	Y	N	M
Do you smoke	Y	N	M
Use tobacco products	Y	N	M
Are you pregnant	Y	N	M



Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: \_\_\_ Marital Status: M/ S/ D/ W

Home Ph: ( ) \_\_\_\_\_ Work Ph: ( ) \_\_\_\_\_ ext: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Ph: ( ) \_\_\_\_\_

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1. Primary Ins Co: \_\_\_\_\_ Relationship to patient: self / spouse / child / other

Policy holder name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: M / F Contact Ph: \_\_\_\_\_ ID/Policy number: \_\_\_\_\_

2. Secondary Ins Co: \_\_\_\_\_ Relationship to patient: self / spouse / child / other

Policy holder name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: M / F Contact Ph: \_\_\_\_\_ ID/Policy number: \_\_\_\_\_

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ACCIDENT INFORMATION: Accident type: none / auto / work / other

Date of accident/injury/onset: \_\_\_/\_\_\_/\_\_\_ Surgery for this injury? Y / N

Surgery Date: \_\_\_/\_\_\_/\_\_\_ State of accident? \_\_\_ Body part: \_\_\_\_\_

Accident details/Reason for visit \_\_\_\_\_

Is there a potential liable party?: Y / N Name of individuals that you allow us to discuss  
your billing and appointments with \_\_\_\_\_

\_\_\_\_\_  
Pt Signature

\_\_\_\_\_  
Date

This is for annual updates only:

- Patient, please initial and date here if the above information is complete and correct \_\_\_\_\_