

**GENERAL INFORMATION**

Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
Occupation \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Employment Address \_\_\_\_\_  
\_\_\_\_\_

**Email Address** \_\_\_\_\_

**Health Insurance:**

(PRIMARY)	(SECONDARY)
Company _____	Company _____
Policy Number _____	Policy Number _____
Policy Holder _____	Policy Holder _____
Policy Holder Date of Birth _____	Policy Holder Date of Birth _____

**Referring Physician:** \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address: \_\_\_\_\_ Phone No. \_\_\_\_\_

WHAT IS THE REASON FOR TODAY'S VISIT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place of Birth \_\_\_\_\_  
High School \_\_\_\_\_ Year Graduated \_\_\_\_\_  
College \_\_\_\_\_ Year Graduated \_\_\_\_\_  
Graduate School \_\_\_\_\_ Year Graduated \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Number of Pregnancies \_\_\_\_\_  
Current Method of Contraception \_\_\_\_\_  
First Day of Last Menstrual Period \_\_\_\_\_  
Date of Most Recent Pap Smear \_\_\_\_\_ Result \_\_\_\_\_  
Date of Most Recent Mammogram \_\_\_\_\_ Result \_\_\_\_\_

List date and description of all past hospitalizations, operations, serious injuries or major illnesses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_  
Date \_\_\_\_\_

Are there any illnesses that occur commonly in your family? If yes, describe.

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List any known allergies to drugs, medicine, foods or anything else.

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Are you under the care of a physician for anything other than the problems that bring you here today? If yes, describe.

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Do you take any medications of any kind on a regular or daily basis? \_\_\_\_\_  
If yes, describe \_\_\_\_\_

How many cigarettes do you smoke each day \_\_\_\_\_

What is your average daily consumption of alcoholic beverages? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING?

Fever	Yes _____	No _____
Weight Loss	Yes _____	No _____
Eye Disease	Yes _____	No _____
Ear, Nose or Throat Disease	Yes _____	No _____
Heart Disease	Yes _____	No _____
Lung Disease	Yes _____	No _____
Gastrointestinal Disease	Yes _____	No _____
Musculoskeletal Disease	Yes _____	No _____
Skin Disease	Yes _____	No _____
Neurological Disease	Yes _____	No _____
Psychiatric Disease	Yes _____	No _____
Breast Disease	Yes _____	No _____
Diabetes	Yes _____	No _____
Blood Disease	Yes _____	No _____