NEW PATIENT INFORMATION

NAME ____ DATE OF BIRTH _______________ SEX: M / F

ADDRESS _____________________________________CITY______________________ STATE________

ZIP___________ HOME PHONE (   ) _________________ WORK PHONE (   ) ____________________

CELL PHONE (   ) ________________ SS #__________________OCCUPATION______________________

ARE YOU PRESENTLY WORKING? Y / N If No, are you disabled or retired?________________________

HIGHEST LEVEL OF EDUCATION COMPLETED? ______________

REASON FOR TODAY'S VISIT? ____

SYMPTOMS	HOW LONG?	TREATMENTS

PAST SURGICAL PROCEDURES	APPROX DATE

OTHER MEDICAL PROBLEMS ____

____

____

FAMILY HISTORY Have any family members (father, mother, grandparents) been diagnosed with any diseases? Y / N (If yes, list below)

Relationship	Disease	Relationship	Disease

SOCIAL HISTORY Alcohol Y / N How much/How Often ___________________ # of Years______________

Tobacco Y / N How much/How Often ___________________ # of Years______________

Recreational Drugs Y / N What Kind ___________How Often _________________ # of Years______________

ALLERGIES AND ADVERSE REACTIONS (List all medication, food or other allergies)

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MEDICATIONS (List prescription and non-prescription medications, nutritional supplements, vitamins, herbal formulas, puffers or inhalers)

WHAT KIND?	HOW MUCH?	HOW OFTEN?
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

ASSISTIVE DEVICES: (Such as a walker, wheelchair, home oxygen, etc.)

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REFERRING PHYSICIAN_ ______________________________ SPECIALTY____________________________

ADDRESS_ ____CITY________________________ STATE________

ZIP___________ WORK PHONE (   ) __________________ FAX # (   ) _____________________

PRIMARY CARE PHYSICIAN _ ____

ADDRESS ____CITY________________________ STATE________

ZIP___________ WORK PHONE (   ) __________________ FAX # (   ) _____________________

OTHER PHYSICIANS INVOLVED IN YOUR CARE:

DOCTOR ____ SPECIALTY _______________________________

ADDRESS ____CITY________________________ STATE________

ZIP___________ WORK PHONE (   ) __________________ FAX # (   ) _____________________

DOCTOR ____ SPECIALTY _______________________________

ADDRESS ____CITY________________________ STATE________

ZIP___________ WORK PHONE (   ) __________________ FAX # (   ) _____________________