Patient Information

Date:_____

Name_____ Home Phone#_____
Address_____ Date of Birth_____
City_____ ST____ Zip_____ Martial Status_____
Family Physician_____ Social Security #_____
Physician's Phone #_____ Referred by_____

Insurance:

Employee/Subscriber_____ Spouse_____
Employer_____ Employer_____
City_____ ST____ Zip_____ City_____ ST____ Zip_____
Insurance Company_____ Insurance Company_____
Group#_____ Group#_____
Social Security #_____ Social Security #_____
Date of Birth_____ Date of Birth_____

Medical Information:

Are you taking any prescription or over the counter medications?_____ [yes] [no]
If yes, please list the medications._____
_____
_____

Are you allergic to:
Penicillin [yes] [no]
Aspirin [yes] [no]
Codeine [yes] [no]
Latex products [yes] [no]
Others_____

Have you ever been told you have mitro value prolapse?_____ [yes] [no]
Have you ever been told you have a heart murmur?_____ [yes] [no]
Have you ever been told you had rheumatic heart disease?_____ [yes] [no]
Do you have a cardiac pacemaker?_____ [yes] [no]
Do you have chest pains?_____ [yes] [no]
Do your ankles swell?_____ [yes] [no]
Do you have heart troubles?_____ [yes] [no]
Have you had a heart attack?_____ [yes] [no]
If yes, about when did this occur?_____
Do you have angina?_____ [yes] [no]
Do you have [high] or [low] blood pressure?_____ [yes] [no]
Do you have diabetes?_____ [yes] [no]
Do you have [asthma] or [seasonal allergies]?_____ [yes] [no]
Have you ever had [hepatitis], [jaundice], or [liver disease]?_____ [yes] [no]
Have you ever had tuberculosis?_____ [yes] [no]
Do you have [fainting spells] or [seizures]?_____ [yes] [no]
Do you have [AIDS] or are you [HIV+]?_____ [yes] [no]
If yes, please list: CD-4 Count_____ Viral Load_____ Neutrophil Count_____
Have you ever taken prescription diet pills?_____ [yes] [no]
Have you had any joint replacements?_____ [yes] [no]
Have you ever had cancer?_____ [yes] [no]
Do you have any sexually transmitted diseases?_____ [yes] [no]
Have you ever had a blood transfusion?_____ [yes] [no]
Have you ever had a blood disorder such as leukemia?_____ [yes] [no]
Woman: Are you [pregnant] or [nursing]?_____ [yes] [no]
Do you take birth control pills?_____ [yes] [no]

Signature, (parent or guardian if a minor)_____