Patient Information

Time:

Ins:
Pre-auth: Y or N

Name: ____
Address: ____________________________Zip Code:__________
DOB: _____________ AGE:_____ Phone #: _______________
Weight: ___________ Height:___________
Will you need a work or school note?___________

Who is your regular doctor? ____________________

What is your chief complaint today? _____________________________

What kind of symptoms are you having?
____
____

When did your symptoms start? ____

Do you have any medical problems (for example: high blood pressure or diabetes)? If yes, please list.
____
____
____

Have you ever had any surgeries? If yes, please list.
____
____
____

Do you take any medications? If yes, please list.
____
____
____
____

Are you allergic to any medications?
____
____

When was your last Tetanus shot? ____
If applicable: Are your child's immunizations up to date? ____________________________________

Women: Date of last period? ____

Do you: Smoke? If yes, how many packs per day? ____
Drink alcohol? If yes, everyday or occasionally? ___________________________________
Use drugs? If yes, what and how often? ____

If family member/s suffer from medical condition/s please list them below.
Father: □ alive □ deceased ____
Mother: □ alive □ deceased ____
Brother/s: □ alive □ deceased ____
Sister/s: □ alive □ deceased ____
Children: □ alive □ deceased ____

BP:	BP:
P:	P:
R:	R:
T:	T:
O2:	O2: