

Name: _____ Birthdate: ___/___/___ Age: _____ SS#: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Work Phone: _____

Email: _____ Sex: M F Cell Phone: _____

Occupation: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Who referred you to this office? _____

Medication Allergies: _____

Current Medications: _____

Do you take aspirin or blood thinners? Yes No Do you have artificial joints or heart valves? Yes NoDo shots or something similar make you faint? Yes No Do you take antibiotics before teeth cleanings? Yes NoFemales: Are you pregnant or breast feeding? Yes No Are you planning or trying to become pregnant? Yes NoHave you traveled in the last year to undeveloped area, South America, Africa, or the India Subcontinent? Yes No**Health Questionnaire:**

Reason for today's visit (CC): _____

Associated symptoms (circle): irritated itch pain bleeding growing changing

What has helped or worsened the condition: _____

Past Medical History:

Please check from the list below or write in current and past medical problems.

Irregular Heart Beat High Blood Pressure Stroke Angina Mitral Valve Prolapse Headache/Migraine Heart Attack Heart Murmur Seizures Heart Transplant Rheumatic Fever Vision Problems/Cataracts Diabetes Asthma Hepatitis Thyroid Disease Seasonal Allergies Kidney/Urine Problems Arthritis Emphysema Stomach/Ulcer Disease Lupus Tuberculosis Skin Cancer Type _____ Other Cancer Type _____

Please List Medical Problems: _____

Family Medical History:

Mother: living/deceased Age: _____ Medical Problems: _____

Father: living/deceased Age: _____ Medical Problems: _____

Brothers/Sisters: _____

Children: No. of Children: _____ Ages: _____

Social History:Do you live alone? No Yes Do you smoke? No Yes amount per day _____Do you drink alcohol? No Yes amount per day _____ Do you use recreational drugs? No Yes-frequency _____

Hobbies/leisure activities: _____

All fees incurred at each office visit are the ultimate responsibility of the patient unless other arrangements are made.

I consent to the release of my medical information for treatment, payment and healthcare operations. Thank you.

Signature: _____ Date: ___/___/___

For Minors, Parent or Guardian consent for future evaluation and treatment is required, if such consent is granted then please sign below:

Signature of Parent or Guardian: _____