PATIENT INFORMATION

Name:			
Last	First	MI	Birthday
Address:			
Street			
City	State		Zip (Coll)
rnone. (nome)	(VVOIK)		(Cell)
M F	_ Social Security:		Marital Status: S M O
Emergency Contact:		Phone/C	ell Number:
Race:		Ethnicity	:
American Indian or AAsianBlack or African AmeNative Hawaiian or 0White			Hispanic or Latino Not Hispanic or Latino
Pharmacy Name & Address: _		Ph	armacy Phone:
	Insurance II	nformation	
Primary Insurance:		I.D. Numbe	er
Full Name of Insured:			DOB:
Secondary Insurance:		I.D. Numbe	er
Full Name of Insured:			DOB:
Signature:			_ Date:
(Patient or legally	responsible adult)		

Primary Care Physician:	Referred by:									
Review of System Circle Yes or No Are you Pregnant? Arthritis yes no High Blood Pressure yes no Arthritis yes no HIV Virus yes no Atthritis yes no Kidney Problems yes no Bladder Problems yes no Numbness / Tingling yes no Bleeding Disorders yes no Persistent Cough yes no Persistent Cough yes no Persistent Cough yes no Persistent Problems yes no Persistent Problems yes no Persistent Problems yes no Presumonia yes no Shortness of Breath yes no Stroke Problems yes no Stroke Problems yes no Stroke yes no Emphysema yes no Stroke Problems yes no Heard Attack yes no Blood Sugar #: Heart Attack yes no Blood Sugar #: Have you had any Complications with surgeries and/or anesthesia? yes no Explain: Alcohol: no <2 4 6 Drinks per week. Smoke: no <1 2 3 Packs per Day. Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no	Primary Care Physici	an:			Last Visit:	Last Visit:				
Review of System Circle Yes or No Are you Pregnant?				Last Blood Pressure	/					
Are you Pregnant?										
Arthritis yes no HIV Virus yes no Asthma yes no Kidney Problems yes no Loss of Balance yes no Bladder Problems yes no Loss of Balance yes no Bladder Problems yes no Numbness / Tingling yes no Persistent Cough yes no Chest Pain yes no Shortness of Breath yes no Shortness of Breath yes no Stroke yes no Stroke yes no Stroke yes no Stroke yes no Ulcers yes no Ulcers yes no Headaches yes no Blood Sugar #:	·									
Arthritis yes no HIV Virus yes no Asthma yes no Kidney Problems yes no Loss of Balance yes no Bladder Problems yes no Loss of Balance yes no Bladder Problems yes no Numbness / Tingling yes no Bleeding Disorders yes no Persistent Cough yes no Chest Pain yes no Pneumonia yes no Stortness of Breath yes no Stortness of Breath yes no Storach Problems yes no Headaches yes no Ulcers yes no Heart Attack yes no Blood Sugar #:	Are you Pregnant?			VOC	no	High Blood Prossure	ves n			
Asthma yes no Kidney Problems yes no Back Problems yes no Loss of Balance yes no Numbness / Tingling yes no Numbness / Tingling yes no Numbness / Tingling yes no Persistent Cough yes no Chest Pain yes no Shortness of Breath yes no Shortness of Breath yes no Stomach Problems yes no Stomach Problems yes no Stroke yes no Ulcers yes no Ulcers yes no Headaches yes no Ulcers yes no Blood Sugar #:	-			•		_				
Back Problems yes no Loss of Balance yes no Bladder Problems yes no Numbness / Tingling yes no Bleeding Disorders yes no Persistent Cough yes no Pneumonia yes no Pneumonia yes no Pneumonia yes no Pneumonia yes no Stomach Problems yes no Stomach Problems yes no Stroke yes no Stroke yes no Emphysema yes no Stroke yes no Ulcers yes no Headaches yes no Blood Sugar #: Have you had any Complications with surgeries and/or anesthesia? yes no Explain:				•						
Bladder Problems yes no Numbness / Tingling yes no Bleeding Disorders yes no Persistent Cough yes no Cancer yes no Pneumonia yes no Chest Pain yes no Shortness of Breath yes no Shortness of Breath yes no Stomach Problems yes no Stomach Problems yes no Emphysema yes no Stroke yes no Epilepsy yes no Ulcers yes no Headaches yes no Blood Sugar #: Headaches yes no Blood Sugar #: Heat Attack yes no Hepatitis yes no Other Medical Problems: Have you had any Complications with surgeries and/or anesthesia? yes no Explain:						•				
Bleeding Disorders				•			•			
Cancer yes no Pneumonia yes no Chest Pain yes no Shortness of Breath yes no Diabetes yes no Stomach Problems yes no Emphysema yes no Stroke yes no Epilepsy yes no Ulcers yes no Headaches yes no Blood Sugar #:							-			
Chest Pain yes no Shortness of Breath yes no Diabetes yes no Stomach Problems yes no Emphysema yes no Stroke yes no Epilepsy yes no Ulcers yes no Headaches yes no Blood Sugar #:	_			•		9				
Diabetes yes no Stomach Problems yes no Emphysema yes no Stroke yes no Epilepsy yes no Ulcers yes no Headaches yes no Blood Sugar #:				•			•			
Emphysema yes no Stroke yes no Ulcers yes no Headaches yes no Ulcers Headaches yes no Headaches yes no Headaches yes no Headaches yes no Hepatitis yes no Other Medical Problems: Have you had any Complications with surgeries and/or anesthesia? yes no Explain: Alcohol: no <2 4 6 Drinks per week. Smoke: no <1 2 3 Packs per Day. Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no							•			
Epilepsy yes no Ulcers yes no Headaches yes no Blood Sugar #:				•			•			
Headaches yes no Blood Sugar #:				•			•			
Heart Attack yes no Other Medical Problems: Have you had any Complications with surgeries and/or anesthesia? yes no Explain: Alcohol: no <2 4 6 Drinks per week. Smoke: no <1 2 3 Packs per Day. Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no							•			
Hepatitis yes no Other Medical Problems: Have you had any Complications with surgeries and/or anesthesia? yes no Explain: Alcohol: no <2 4 6 Drinks per week. Smoke: no <1 2 3 Packs per Day. Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no						Blood Sugal #.				
Other Medical Problems: Have you had any Complications with surgeries and/or anesthesia? yes no Explain: Alcohol: no <2 4 6 Drinks per week. Smoke: no <1 2 3 Packs per Day. Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no				•						
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Smoke: no <1 2 3 Packs per Day. Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no	Explain:									
Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.) Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no	Alcohol: no	<2	4	6	Drink	s per week.				
Allergic to: Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no	Smoke: no	<1	2	3	Packs	s per Day.				
Penicillin yes no Sulfa yes no Adhesive Tape yes no Local Anesthesia yes no	Family Medical Histo	ry: (Diab	etes, Hi	gh Blood	l Pressur	re, Cancer, etc.)				
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	•		-		-					
Medications now taking:	Medications now tak	ing:								