General Information

Name: _____

DOB: _____ Age: _____Sex:_____

Address: _____

City/State/Zip:_____

Preferred Phone #: _____ ☐ Cell ☐ Home ☐ Work

Alternate Phone #:_____ ☐ Cell ☐ Home ☐ Work

Email:_____

Can we communicate with you via Text: ☐ Yes ☐ No via email: ☐ Yes ☐ No

Emergency Contact:_____

Emergency Contact's Relationship with me:_____

Emergency Contact's Phone #:_____ ☐ Cell ☐ Home ☐ Work

Please write the name(s) of your insurance & show the card at front desk for scanning

If you want us to send notes to your doctors, please write their names below

Please write/describe the reason for your visit

Please list any medications you are allergic to

Please list the medications you are currently taking or attach the medicine list

Check if you have/had any of the following medical conditions

☐ Asthma/Bronchitis	☐ Blood Clot in Lungs or Legs	☐ Seizures	☐ Cancer
☐ Emphysema	☐ High Blood Pressure	☐ Stroke	☐ HIV

☐ Other

Social History

- Do you smoke? ☐ Yes ☐ No
- If yes, how much_____& for how many years_____
- If no, then did you smoke in past? ☐ Yes ☐ No
- If yes, how much_____& when did you quit_____

Please write any medical conditions that run in the family