## Patient History Sheet (please print)

Date: Patient:			SS#			
Date: Patient:	Last Name First Name	Initial	(Preferred	-Name)		
Mailing Address:						
Trianning / Iddiess:	#	City		State	<u> </u>	Zip
Telephone Home:	Work:	· ·	Cell:			
Date of Birth:	Age: Male	e/Female	$\square$ single	□ married □	widowed	☐ divorced
Race: Ethnicit	y:	Language:				
Date of Birth:  Race: Ethnicit e-mail:	Emergency Con	tact Name		Pho	ne	
Employer Name:	O			Occupation:Date of BirthRelationship:		
Spouse Name:	Employer: _			Date of I	Birth	
Who is responsible for this ac	count:	3.7	D 71	_Relationship:		
Primary Insurance:		Name or	ı Policy:			
Primary Policy No:			Gro	up No.:		·
Primary Insurance: Primary Policy No: Secondary Insurance:	Nami	e/Policy No: <sub>.</sub>				
Referred by:						
If accident, give date and desc	ription					
· <del>-</del>		al History	7			· · · · · · · · · · · · · · · · · · ·
Family Physician		v		vsical		
PERSONAL MEDICAL					FAMIL	Y MEDICAL
☐ Heart Problems	☐ Epilepsy		Rheumatic	Fever	☐ Skin Car	
☐ High Blood Pressure	☐ Headaches		Sinus Prob	~~~~	□Breast C	Cancer
☐ Circulatory Problems	☐ Hepatitis, Jaundice or Liv		AIDS		☐ Diabete	s
☐ Nervous Problems	□ Cancer		Immunode	ficiency Disorders	☐ High B	lood Pressure
☐ Radiation Treatment	☐ Psychiatric Care		Hemophili			
☐ Artificial Heart Valves or Joints	☐ Chronic Diarrhea		Stroke			
☐ Recent Weight Loss	☐ Allergies to Medicine or	Drugs 🗆	Ulcer			
☐ Back Problems	☐ General Allergies		Venereal I	Disease		
□ Diabetes	☐ Arthritis		Drug /Alco	ohol Dependency		
☐ Respiratory Problems	☐ Blood Disease		Cigarette/1	Γobacco Use		
D 1 1 1 1 1	, ## • 7	7 7	7		7	
Do you have any drug/tape/la	tex allergies or have you	ever naa an i	aaverse re	action to any m	edication?	
☐ Yes, Explain						
Have you ever responded adv	ersely to medical or denta	ıl treatment?	$\square No \square$	Yes, Explain _		
Are you taking any medication	ns (including over the coi	<b>inter</b> /non-pr	escription)	? □ No □ Yes	i, What	
Are you under the care of a p	hvsician? □ No □ Yes. I	For what con	dition			
Height Weight	lbs. Weight loss	or gain in th	ne past yea	r1bs	. 🗆 Loss	s 🗆 Gain
Do you suggest that you are n	romant? [] Vac [] No. /	l ea van annai	na? □ Va	ua □ No. Dove		□ <b>V</b> □ <b>X</b>
Do you suspect that you are p	regnant u resu no A	are you nursi	ng: Ure	s ino Doye	u smoke?	⊔ Yes ⊔ No
Is there anything else we sho	ould know about your m	edical histor	y?			
The above information is accurate and comp or any member of his staff responsible for an concerning my illness and treatment to my in I understand that I am responsible for any a arrange payment. All balances over 90 days Center Financial Policy and have no question	ny errors or omissions that I may have nsurance company and assign to the ph mount not paid by insurance. I agree to are subject to a monthly finance charg	made in the comple sysician all paymen o pay the balance w	etion of this form ts for medically within 30 days o	n. I herby authorize my approved services ren freceipt of invoice or co	v physician to fur idered to myself ( all the Accounts	nish information or my dependents. Manager to
Date	Patient's Signature					
<del></del>		· · · · · · · · · · · · · · · · · · ·		·		