

Thank you for selecting our facility for your medical care.  
We are committed to do the very best we can to provide you with excellent professional care.

Patient Name (Last, First, MI)	Occupation	Primary Care Physician	Dexterity <input type="checkbox"/> R-Handed <input type="checkbox"/> Left-Handed
Your Current Health Condition:	Current Medications (daily)	Allergies (medication, food, dyes, etc.)	

Mark the following medical conditions appropriately.

- ❖ If you are unsure how to answer, please mark with a "?" or ask someone at the front desk prior to submitting this form in.
- ❖ **If there is a history** of a condition however you have **never** suffered from it, mark **"No"** as well as **"History."**

Condition	Yes	No	History	Condition	Yes	No	History
Pain or Pressure in Chest				Thyroid Problem or Goiter			
Palpitations or Pounding Heart				Severe Tooth or Gum Problem			
Shortness Of Breath				Problematic Shoulder or Elbow			
High or Low Blood Pressure				Problematic Knee			
Dizziness of Fainting spells				Loss of Finger or Toe			
Trouble with Sleep Pattern				Bone, Joint, or other Deformity			
Sleepwalking				Swollen or Painful Joints			
Heart Condition				Leg Cramps			
Diabetes				Nerve Injury			
Tumor, Growth, Cyst, or Cancer				Indigestion or GERD			
Chemotherapy				Epilepsy or Seizure			
Diabetes, Stroke				Gallbladder Condition/Gallstones			
Frequent or Painful Urination				Hernia			
Kidney Stone or Blood in Urine				Stomach, Liver, Intestinal Problems			
Hemorrhoids or Rectal Disease				Foot Problems			
Asthma				Skin Disease			
Frequent Anemia				Recurrent Ear Infections/Pain			
Hay Fever or Allergies				Loss of Memory/Amnesia			
Easily Fatigued				Periods of Unconsciousness			
Chronic Sinus Infections				Paralysis (includes Infantile)			
Chronic or Frequent Colds				Eye Conditions/Lack of Vision			
Chronic Cough				Corrective Eye Surgery			
Blood in Saliva or when Coughing				Wear Corrective Lenses			
Weakened Immune System				Hearing Loss			
Arthritis, Rheumatism, or Bursitis				Wear a Hearing Aide			
Recurrent Back Pain or Injury				Wear a Brace or Support			
Frequent or Severe Headaches				Toxic Chemical Exposure			
Head Injury				Depression or Anxiety			
Recent Weight Change (extreme)				Suicide Attempts or Plans			
Eating Disorder (Anorexia, Bulimia, NOS)				Used Tobacco			
Incontinence – Lack of Bladder Control				Used Illegal Drugs			
Speech Impediment or Stutter				Consumes Alcohol more than 3x/week			
Motion Sickness				Been Refused a Job for Medical Reasons?			
Radiation Therapy or X-Rays				Been Refused Life Insurance?			
Scarlet Fever				Been Advised to/had Operation(s)?			
Rheumatic Fever				Been Treated for a Mental Condition?			
Jaundice or Hepatitis				<b>Females Only</b>			
Tuberculosis or Positive PPD Test				Treated for a Female Disorder?			
Contact with TB Carrier				Irregular Menstrual Cycle?			
Plate, Pin, Rod in any Bone				Last Menstruation (end)	(MM/DD/YY)	/	/
Sexually Transmitted Disease				Last Pap Smear	(MM/DD/YY)	/	/
Plastic or Cosmetic Surgery				Last Mammogram	(MM/DD/YY)	/	/

I understand that this information is referenced for **my treatment only**. I certify that I have reviewed the preceding information and that I have completed it truthfully and to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian (if patient is minor)      Relationship to patient      Date

If you are physically incapacitated and/or do not understand the above information, please notify the receptionist upon turning this in. You are to sign this after revisal.	_____	_____
	Reviewed by:	Date