

Patient Name: _____

Date: _____

Is it okay to call you at work? Yes No

How did you hear about our clinic? Or who referred you?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Physician: Dr. _____ |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Health Class | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other: _____ |

If you selected 'Yellow Pages', please indicate which one: Dex Community Yellow Pages

If you selected 'family member' or 'friend', please tell us who so we may thank them: _____

Medical Conditions:

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke | |

Surgeries:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Cardiovascular Procedure | <input type="checkbox"/> Cervical Disc Procedure |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Neck Surgery |
| <input type="checkbox"/> Radical Prostatectomy | <input type="checkbox"/> Transurethral prostate surgery | | |

Allergies:

- | | | | |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish & Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat / Gluten | |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less / day |
| <input type="checkbox"/> Smoke more than 1 pack / day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seatbelts never | <input type="checkbox"/> Wear seat belts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart Problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High Blood Pressure (parent) | <input type="checkbox"/> High Blood Pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | | |

Substance Abuse:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbituates (past) | <input type="checkbox"/> Barbituates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | | |

Male Children: Under 6 years Under 10 years Under 19 years

Female Children: Under 6 years Under 10 years Under 19 years

Occupational Activities:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical / secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare / childcare | <input type="checkbox"/> Executive / legal | <input type="checkbox"/> Food service |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equip. operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |
| <input type="checkbox"/> Military | <input type="checkbox"/> Police / fire | <input type="checkbox"/> Professional services | <input type="checkbox"/> Retail worker |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Truck driver | | |

Recreational Activities:

- | | | | |
|--------------------------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Backpacking | <input type="checkbox"/> Biking | <input type="checkbox"/> Boating | <input type="checkbox"/> Football |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Racketball | <input type="checkbox"/> Running | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Tennis | <input type="checkbox"/> Walking |