

Patient's Name (Please Print)	S.S.#	Marital Status					Sex		Birth Date	Age	Ethnic Origin
		S	M	W	D	SEP	M	F			

Occupation (Indicate if student) _____

Person to Notify in Emergency _____ Daytime Phone _____ Relationship _____

Last Physical Examination Date _____ By Doctor _____ Phone _____

Family or Referring Doctor _____ Phone _____

Describe briefly your present medical symptoms and anything else that we should know _____

Operations you have had _____ Year _____

Family history Any blood relatives who have or had any of the listed conditions.

Conditions	Yes No		Relationship	Conditions	Yes No		Relationship	Test and Immunizations	Yes No		Year done
Asthma				Hay Fever				Tetanus (DPT)			
Arthritis				Insanity				Diphtheria			
Allergies				Kidney Disease				Measles			
Anemia				Leukemia				Mumps			
Alcoholism				Migraine				Rubella			
Bleeding Tend.				Nervous Break'n				Polio			
Cancer				Obesity				Flu Shot			
Colitis				Rheumatism				Pneumonia Vaccine			
Congenital Heart				Rheumatic Fever				TB Skin Test (P.P.D)			
Diabetes				Stroke				HAVE YOU EVER HAD?	YES	NO	YEAR
Epilepsy				Suicide				Viral Hepatitis			
Goiter				Stomach Ulcers				Gonorrhea			
High Bld. Pressure				Tuberculosis				Syphillis			
Heart Disease								Tuberculosis			

Current Medications _____ Drugs you are Allergic to _____

Habits:

Do You:	Yes	No	Amount:	
Smoke	<input type="checkbox"/>	<input type="checkbox"/>		_____ packages
Drink Coffee	<input type="checkbox"/>	<input type="checkbox"/>		_____ cups
Drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		_____ oz.
Drink Beer	<input type="checkbox"/>	<input type="checkbox"/>		_____ oz.

Have you ever traveled to:

Africa	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Year _____
Asia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Year _____
Central America	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Year _____

Do you have any pets? Yes No