



Initial History Form

FIRST NAME _____ MI _____ LAST NAME _____

DOB _____ AGE _____ SEX _____ SS# _____ - _____ - _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RACE _____ HISPANIC OR LATINO Y N

MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED

EMPLOYMENT STATUS: EMPLOYED UNEMPLOYED FT STUDENT OTHER RETIRED

EMPLOYER NAME _____ EMPLOYER PHONE # _____

HOME PHONE _____ WORK PHONE _____ EXT _____

CELL PHONE _____ EMAIL ADDRESS _____

DO YOU CONSENT TO TEXT/EMAIL APPOINTMENT REMINDERS? * Y N

**BY CIRCLING YES, YOU ARE AGREEING TO STANDARD TEXT MESSAGING RATES*



EMERGENCY CONTACT INFORMATION

EMERGENCY FIRST NAME _____ EMERGENCY LAST NAME _____

EMERGENCY PHONE # _____ RELATIONSHIP TO PATIENT _____

EMERGENCY ADDRESS _____

EMERGENCY CITY _____ STATE _____ ZIP _____

GUARANTOR INFORMATION: CIRCLE ONE SELF OR OTHER

IF ANOTHER PERSON IS IN CHARGE OF YOUR INSURANCE COMPLETE THE FOLLOWING INFORMATION:

FIRST NAME _____ LAST NAME _____

DOB _____ SEX _____ SSN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

PRIMARY CARE DOCTOR _____

DATE LAST SEEN _____

WHAT BRINGS YOU IN TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT TYPE OF TREATMENT HAVE YOU TRIED? _____

Social History

DO YOU USE TOBACCO? YES NO

IF SO: (PLEASE CIRCLE THE CORRECT RESPONSE)

CIGARETTES _____ PPD CIGARS PIPE CHEWING TOBACCO

DO YOU DRINK? YES NO HOW OFTEN? _____

MEDICAL HISTORY

PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING

ANEMIA	ANXIETY	ARTHRITIS	ASTHMA	BACK PROBLEMS	BPH	BREAST CANCER
CAD	CANCER	CHF	HIGH CHOLESTEROL	COPD		DEMENTIA
DEPRESSION	DEMATITIS	DIABETES	EPILEPSY	GERD	GLAUCOMA	GOUT
HEADACHE	HEPATITIS	HIV	HYPERTENSION	MI	MIGRAINE	PNEUMONIA
RENAL STONE	STROKE	TB	THYROID PROBLEMS		ULCER (GI)	

PROVIDE DATES FOR ANY CIRCLED ANSWERS _____

ADDITIONAL MEDICAL PROBLEMS _____

ALLERGIES

PLEASE LIST ALLERGIES AND THE REACTION THAT YOU SUFFERED

MEDICATION _____ REACTION _____

MEDICATION _____ REACTION _____

MEDICATION _____ REACTION _____

MEDICATION _____ REACTION _____



