INITIAL HISTORY FORM

FIRST NAME____________________MI____LAST NAME________________________

DOB_________________AGE________SEX_________SSN#____________________

ADDRESS____

CITY__________________________STATE________ZIP_________________________

RACE__________________________________HISPANIC OR LATINO Y N

MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED

EMPLOYMENT STATUS: EMPLOYED UNEMPLOYED FT STUDENT OTHER

EMPLOYER NAME___________________________EMPLOYER PHONE_______________

HOME PHONE____________________WORK PHONE__________________EXT________

CELL PHONE______________________EMAIL ADDRESS___________________________

EMERGENCY CONTACT INFORMATION

EMERGENCY FIRST NAME____

EMERGENCY LAST NAME____

EMERGENCY PHONE____

RELATIONSHIP TO PATIENT____

EMERGENCY ADDRESS____

EMERGENCY CITY________________________STATE___________ZIP____________

GUARANTOR RELATION TO PATIENT SELF OR OTHER (circle one)

IF OTHER:

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?_____________________________

____

GUARANTOR RELATION TO PATIENT SELF OR OTHER (circle one)

IF OTHER:

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?____________________________________

____

MEDICAL HISTORY

Please circle if you have any of the following

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

PROVIDE DATES FOR ANY CIRCLED ANSWERS________________________________

____

ADDITIONAL MEDICAL PROBLEMS____________________________________

____

SOCIAL HISTORY

DO YOU USE TOBACCO? YES NO

IF SO: (please circle correct response)

CIGARETTES ______PPD CIGARS PIPE CHEWING TOBACCO

DO YOU DRINK? YES NO HOW OFTEN__________

YOUR MEDICATIONS

MEDICINE NAME DOSEAGE HOW OFTEN DO YOU TAKE MEDICINE?

1____

2____

3____

4____

5____

6____

7____

8____

9____

10_______________________________________

ALLERGIES

PLEASE LIST ALLERGIES AND THE REACTION THAT YOU SUFFERED

MEDICATION____________________ REACTION________________

MEDICATION____________________ REACTION________________

MEDICATION____________________ REACTION________________

MEDICATION____________________ REACTION________________

YOUR MEDICATIONS

MEDICINE NAME ____________ DOSEAGE ____________ HOW OFTEN DO YOU TAKE MEDICINE?

1____

2____

3____

4____

5____

6____

7____

8____

9____

10____

ALLERGIES

PLEASE LIST ALLERGIES AND THE REACTION THAT YOU SUFFERED

MEDICATION____________________________REACTION____________________

MEDICATION____________________________REACTION____________________

MEDICATION____________________________REACTION____________________

MEDICATION____________________________REACTION____________________

LIST ANY SURGERIES YOU HAVE HAD AND DATE IT WAS PERFORMED

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

11. ____

12. ____

13. ____

[illegible]