Please complete and print this form and bring it to your first appointment.

INSURANCE INFORMATION

Patient' Name: _____Age:_____

Name of Primary Insurance: _____

Are you the primary card holder? ◉ yes ○ no

Name of Secondary Insurance: _____

Are you the primary card holder? ◉ yes ○ no

If you are not the primary card holder on either insurance, please complete the following:

Name of Insured: _____ Relationship to Patient: _____

Date of Birth of Insured: _____ SSN of Insured: _____

Insured's Employer:_____Phone:_____

MEDICAL INFORMATION

Referring Doctor: _____Primary Care Doctor:_____

Briefly describe your symptoms:

How long have you had this problem? _____

Please list ALL medications that you currently take:

Medication (e.g. Aspirin)	Dose (81 mg)	How often? (once per day)

To what medications are you allergic?

1.	2.	3.
4.	5.	6.

PAST MEDICAL INFORMATION

Do you or have you ever had any of the following conditions? Check all that apply:

☐ Arthritis: ☐ Osteoarthritis ☐ Rheumatoid Arthritis
☐ Asthma ☐ Emphysema / COPD
☐ Cancer: (what kind?)_____
☐ Diabetes
☐ Heart Disease: (what kind?)_____
☐ Hepatitis: ☐ A ☐ B ☐ C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Osteoporosis ☐ Osteopenia
☐ Stomach Ulcers ☐ Heartburn ☐ Haital Hernia
☐ Stroke
☐ Thyroid problems

Other past medical problems not listed above:

Please list all of your previous surgeries:

1.
2.
3.
4.
5.
6.
7.

FAMILY HISTORY

OTHER THAN YOU, does anyone in your family have:

☐ Spine problems
☐ Spina Bifida
☐ Brain problems (what kind?)_____
☐ Heart disease ☐ High Blood Pressure ☐ Diabetes
☐ Cancer (what kind?) _____

SOCIAL HISTORY

Do you smoke? ◉ No ○ Yes How many packs per day? _____
Do you drink alcohol? ◉ None ○ 0-2 drinks/day ○ 3-5/day ○ more than 5/day
Do you use recreational drugs? ◉ No Yes ○
Your Job title and brief description of your duties: _____

_____

Marital Status: _____
Number of children: ____
Ages of Children _____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

General: ☐ Fever ☐ Night Sweats ☐ Weight Loss
Skin: ☐ Rash ☐ Itching
Eyes: ☐ Vision problems ☐ Eye discomfort/pain
Ears: ☐ Hearing loss ☐ Ear infection ☐ Ringing in the ear
Nose: ☐ Nose bleeds ☐ Cold/Flu ☐ Clear drainage from nose
Neck/throat: ☐ Hoarseness ☐ Swollen Glands ☐ Trouble swallowing
Breast: ☐ Lump in breast ☐ Nipple discharge
Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing
Heart: ☐ Chest pain ☐ Palpitations
Gastrointestinal: ☐ Nausea/vomiting ☐ Heartburn ☐ Diarrhea
☐ Bloody stools ☐ Abdominal pain/cramps ☐ Bowel Incontinence
Urinary: ☐ Burning ☐ Blood in urine ☐ Frequent urination
☐ Urinary urgency ☐ Urinary incontinence
Hematological: ☐ Easy Bruising ☐ Easy Bleeding
☐ Excessive bleeding during a previous operation
Psychiatric: ☐ Depression ☐ Claustrophobia
Neurological:

- ☐ Headache
- ☐ Loss of Consciousness
- ☐ Dizziness/Vertigo
- ☐ Double Vision
- ☐ Poor Balance/ Frequent Falling
- ☐ Seizures ☐ Weakness in arms or legs
- ☐ Paralysis ☐ Numbness in arms or legs

PRINT FORM