

TELL US ABOUT YOU

Full Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ S.S. Number: _____
Phone Numbers: Home: _____ Work: _____
Pager: _____ Cellular: _____
Employer: _____ How Long? _____ Occupation: _____
Marital Status: _____ Spouse's Name: _____
Phone Number: Work: _____ Other: _____
Whom May We Thank For Referring You ? _____

IN CASE OF EMERGENCY CONTACT:

(Someone not living with you.)

Name: _____ Relation: _____ Phone: _____
Address: _____ Work Phone: _____
Physician's Name: _____ Street: _____ City: _____

HEALTH QUESTIONS...HAVE YOU EVER HAD:

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney or Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease or Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Bleeding Tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease (or Goiter)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach or Intestinal Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancies (Cancer)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemo or Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Are You Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV Infection or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		

PLEASE ANSWER THESE COMPLETELY:

Are you being treated by a physician now? Yes No For what reason(s)? _____

Are you taking any medications at the present time? Yes No Which medication(s)? _____

Are you sensitive or allergic to any medications? Yes No List names and reaction: _____

Have you ever been hospitalized? Yes No List reasons and dates: _____