PATIENT'S HISTORY FORM DATE _____

Please Print **(use only black ink)**

Last Name_____ First _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____Gender: [ ] Male [ ] Female DOB _____ Age _____

Insurance Co. _____ Policy# _____

Employer & Phone Number _____

Spouse's Name _____ DOB _____ SS# _____

Spouse's Employer & Phone Number _____

Referred by: _____

Occupation:
[ ] Professional / Technical
[ ] Tradesman
[ ] Clerical
[ ] Homemaker
[ ] Production
[ ] Service / Retail
[ ] Other _____

Marital Status:
[ ] Married
[ ] Widowed
[ ] Separated
[ ] Divorced
[ ] Never Married

Education Level:
[ ] less than 12 years
[ ] High School
[ ] 1-4 years college
[ ] Beyond 4 years college
[ ] Professional school

Date of last X-rays/ Imaging Studies _____

Do you NOW have any of the following conditions (MARK ONLY IFYES)

[ ] Congestive Heart Failure?
[ ] Chronic Lung Disease (including Bronchitis of Emphysema)?
[ ] Blindness of trouble seeing, even when wearing glasses?
[ ] Deafness or trouble hearing?
[ ] Sugar Diabetes (Diabetes Mellitus) Type 1?
[ ] Sugar Diabetes (Diabetes Mellitus) Type II adult onset?
[ ] Asthma?
[ ] Ulcer or gastrointestinal bleeding (not counting Hemorrhoids)?
[ ] Arthritis or Rheumatism?
[ ] Sciatica of chronic back problem?
[ ] Hypertension of High Blood Pressure?
[ ] Angina?
[ ] Heart Attack of Myocardial Infarction?
[ ] Stroke?
[ ] Kidney disease?
[ ] Cancer?
[ ] Depression?
[ ] Other? _____

[ ] Do you smoke? If you smoke cigarettes, how many to you smoke in anaverage day?

[ ] Less then ½ pack [ ] ½ to 1 pack [ ] 1 to 2 packs [ ] More than 2 packs

[ ] Do you drink? If you drinkalcohol, about how many drinks in an average day?

[ ] 1 [ ] no more than 1 [ ] 1 or 2 drinks [ ] 3 to 5 drinks [ ] 6 to 8 drinks

1. List all medications 9including over counter products)

_____

2. List all operations / surgeries you have had:

_____