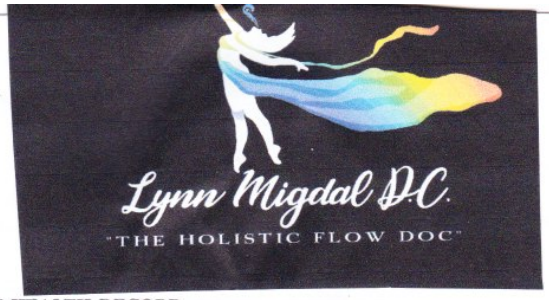


CONFIDENTIAL PATIENT HEALTH RECORD Date_____

Name_____ Male/Female (M/F) _____ Home Phone _____

Street_____ Apt. # _____ City _____ Zip Code _____

E-mail_____ Cell Phone: _____

Age _____ Birth Date _____ Marital Status: Single___ Married ___ Widow (er) ___ Divorced ___ How Many Children ___

Occupation _____ Employer _____

Address _____ Office Phone_____

Name of Wife or Husband _____ Occupation _____

Employer_____ Office Phone_____

Patient's Nearest Relative_____ Phone _____

Referred by _____ If insurance claim, name of company _____

Present family doctor _____ Address_____

Date of last physical examination_____ By Doctor _____ Pregnant? Yes ___ No ___

LIST PRESENT COMPLAINTS:

1. _____ For how long _____
2. _____ For how long _____
3. _____ For how long _____
4. _____ For how long _____
5. _____ For how long _____

Cause of injury/illness:_____

_____

Date of Injury: _____

Remarks:_____

_____

_____

LIST OTHER DOCTORS CONSULTED FOR THIS CONDITION(S):

Name _____ Address_____

Diagnosis _____ Results _____

Name _____ Address_____

Diagnosis _____ Results _____

See other side

What Surgery Have You Had?

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

List Serious Accidents and Falls

What _____ When _____

What _____ When _____

What _____ When _____

What _____ When _____

List Fractures

What _____ When _____

What _____ When _____

Remarks _____

_____

List Medications and/or Diet Supplements You Take:

What _____ Frequency_____ Doctor _____

What _____ Frequency_____ Doctor _____

What _____ Frequency_____ Doctor _____

What _____ Frequency_____ Doctor _____

Remarks _____

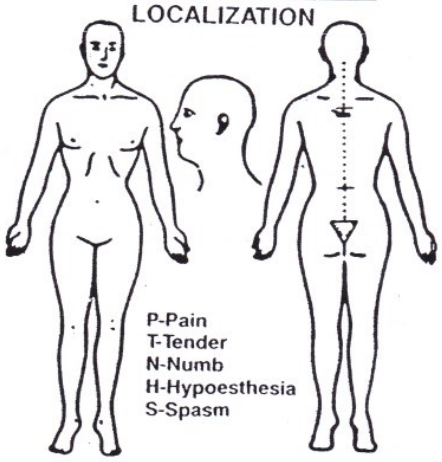
_____

Do You Smoke? ❑ Yes ❑ No

Do You Drink Alcohol? ❑ Yes ❑ No

Check Any of the Following Diseases You Have or Have Had:

Appendicitis	Malaria	Chicken pox	Alcoholism
Scarlet fever	Tuberculosis	Diabetes	Venereal Infection
Diphtheria	Whooping cough	Cancer	Arthritis
Typhoid fever	Anemia	Heart Attack	Epilepsy
Pneumonia	Measles	Goiter	Mental disorder
Rheumatic fever	Mumps	Influenza	Lumbago
Polio	Small pox	Pleurisy	Eczema
AIDS	HIV positive	Low Blood Sugar	



Draw an "X" where you are feeling the symptoms.

Check any of the following you have or have had repeatedly in the past five years:

General symptoms

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in arms, hands or legs
Allergy
Neuralgia

Eyes, ears, nose and throat

Failing vision
Near sightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma
Dental decay
Gum trouble
Thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
TMJ
Jaw clicking

Skin

Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy

Respiratory

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing
Asthma
Emphasema

Cardio-vascular

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Previous heart stroke
Hardening of the arteries
Swelling of ankles
Poor circulation
Paralytic stroke

Muscle and joint

Stiff neck
Back ache
Swollen joints
Tremors
Painful tail bone
Foot trouble
Pain between shoulders
Hernia
Spinal curvature
Faulty posture

Genitourinary

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection or stones
Bed wetting
Inability to control urine
Prostate trouble

Gastrointestinal

Poor appetite
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

Female

Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or back ache
Prev ous miscarriage
Va ,inal discharge
Congested breast
Lumps in breast
Menopausal symptoms

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ S S # _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.