Name:____ Gender:_____ DOB:_________ Date:_________

Address:________________________________ City:__________________ State:_____ Zip:__________

Primary Phone: ______________________________ Alternate Phone:______________________________

Email:____________________________

May we contact you by Phone: Yes___ No___

Email: Yes___ No___

Mail: Yes___ No___

Whom may we thank for referring you to this office:____

Height:______ Weight:______ Occupation:____

Married:____ Divorced:____ Single:____ Widowed:____

Emergency Contact Name:___________________________________ Phone:________________________

Name of your Primary Care Physician:____

Medications/Vitamins/Supplements Currently Taking (OTC/Prescribed/Self):

Medication	Dose	Reason	How long you have been taking

Known allergies to drugs/medications:

____

Self or Family History of: √=Self, F=Family -Please include date of diagnosis-

Heart Disease:_______ Tuberculosis:________ Diabetes:__________________ Thyroid Disorder:_____

Stroke:_____________ HIV:_______________ High Blood Pressure:_________ Seizure disorders:_____

Cancer:____________ Hepatitis:____________ Clotting Abnormalities:_______ Pacemaker__________

Any Other Known Medical Diagnosis:____

____

Any Accidents/Sugeries/Hospitalizations:____

____

List Amount and Frequency (ie. per wk/per day):

Alcohol:_____ Coffee/Tea:_____ Marijuana:_____ Water:_____

Tobacco:_____ Soda Pop:_____ Other Recreational Drugs:_____

Female:

Age of Menarche:_____ Age of Menopause:_____ # of Pregnancies:_____ # of Live Births:_____

# of Children:_____ Last Date of Pap Exam:_____

Are you Pregnant? Y:___ N:___ Not Sure:___

PMS (√): None:___ Slight:___ Moderate:___ Severe:___

Menopausal Syndrome (√): None:___ Slight:___ Moderate:___ Severe:___

(√) all that applies: -Please include date of diagnosis-

Fibroids:______ Endometriosis:______ Ovarian Cysts:______ Fibrocystic Breasts:_____ PID:______

Male:

Last Date of Prostate Exam:_____ PSA/Manual Results:____

(√) all that applies:

Delayed Stream:___ Dribbling:___ Incontinence:___ Impotence:___ Retention of Urine:___

Groin Pain:___ Back Pain:___ Testicular Pain:___ Deceased Libido:___ Increased Libido:___

Please list your feeling toward the following subjects: (√)

	Great	Good	Fair	Poor	Bad	N/A
Work:	____	____	____	____	____	____
Partner:	____	____	____	____	____	____
Self:	____	____	____	____	____	____
Family:	____	____	____	____	____	____
Diet:	____	____	____	____	____	____
Exercise:	____	____	____	____	____	____
Sex:	____	____	____	____	____	____

Please list any of the following that apply: (√) = Occasional (+) = Frequent

Chest Pain___
Short of Breath___
Palpitations___
Sleep Difficulty___
Mental Restlessness___
Dark Urine___
Burning Urination___
Eye Problems___
____
Frequent Colds___
Nasal Congestion___
Skin Disorders___
Allergies___
Easy to Sweat___
Cough___
Constipation___

Hemorrhoids___
Diverticulitis___
____
Diarrhea___
Loose Stool___
Flatulence___
Belching___
Abdominal Pain___
Heavy Sensation___
Fatigue___
Weight Loss___
Obsessive___
Lack of Appetite___
Excessive Appetite___
Vomiting___
Indigestion___

Distention___
Rib-side Pain___
Cold Hands/Feet___
Headaches___
Brittle Nails___
Muscle Spasms___
Jaundice___
Gall Stones___
Twitches___
Dizziness___
Anger/Frustration___
____
Frequent Urination___
Cold Sensation___
Hot Sensation___
Knee Pain___

Decreased Libido___
Ear Ringing___
Edema___
Asthma___
Hair Loss___
Easily Bruised___
Blood in Stool___
Hearing Impairment___
Low Back Pain___
Fear___
Incontinence___

Conditions for which seeking treatment:____

____

____

Previous treatment for these conditions:____

____

____

Any other information you would like to share or express:_____________________________________

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