PATIENT NAME: _____ **Date of birth:** _____

Is this condition interfering with work, sleep, or daily routine? Please explain _____

_____

Have you had similar conditions in the past? _____ Explain: _____

_____

Have you been treated by a Physician for this condition? _____ If yes, please explain: _____

_____

Please list past <u>surgeries</u> and dates: _____

_____

List any <u>allergies</u>: _____

_____

Smoking: Do currently smoke? Yes___ No ___ If yes, how many per day? ____
Have you smoked in the past? Yes___ No___ How long <u>did</u> you smoke?_____
How many <u>did</u> you smoke per day? _____ Do you use smokeless tobacco? Yes__No__
Are you at risk for second hand smoke? Yes___No___

<u>Your</u> Current Medical History: (eg: Diseases, Conditions, Syndromes with corresponding medication/s—please include over the counter medications and supplements.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please use back of form if you require more space.
Significant <u>FAMILY</u> History: (eg: Diseases, Conditions, Syndromes)_____

_____

_____

_____

Height:_____ **Weight:**_____ **Shoe Size:**_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the Doctor and Staff to perform any necessary services needed during diagnosis and treatment.

Signature:_____ **Date:**_____

Signature of parent or guardian if patient is a minor:_____

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