|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PERSONAL INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | E-Mail: | | | | | | | | | | | | | | | | | | | | | | Race (optional): | | | | | | | | | | |
| Date of birth: | | | | | Male or Female | | | | | | | | SSN: | | | | | | | | | | | | | | | Phone: | | | | | | | | | | | |
| Alternate Phone: | | | | | Local Pharmacy: | | | | | | | | | | | | | | | | | | | | Mail Order Pharmacy: | | | | | | | | | | | | | | |
| Mailing Address: | | | | | | | | | | | | | | | City: | | | | | | | | | | State: | | | | | | | | ZIP Code: | | | | | | |
| Physical Address | | | | | | | | | | | | | | | City: | | | | | | | | | | State: | | | | | | | | Zip Code | | | | | | |
| Insurance Name: | | | | | | | | | | ID#: | | | | | | | | | | | | | | | | | | Policy Holder: | | | | | | | | | | | |
| Previous Physician: | | | | | | | | | | | | | | | | Current Established Family: | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency Contact: | | | | | | | | | | | | Relationship: | | | | | | | | | | | Contact Phone: | | | | | | | | | | | | | | | | |
| Complete list of current prescription and over the counter medications See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | Dose: | | | | | | | | | | 2. | | | | | | | | | | | | | | | | | | Dose: | | |
| 3. | | | | | | | | | Dose: | | | | | | | | | | 4. | | | | | | | | | | | | | | | | | | Dose: | | |
| **HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS FOR PAIN IN THE LAST 12 MONTHS?** (Circle yes or no) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **YES** | | **NO** |
| If YES, list Why, Medication, and Dose: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current and past Medical history (Please list) See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| **Do you suffer from any type of Chronic Pain?** | | | | | | | | | | | **YES** | | | | **NO** | | If YES, please explain. | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have history of Substance or Alcohol Abuse?** | | | | | | | | | | | **YES** | | | | **NO** | | If YES, please explain. | | | | | | | | | | | | | | | | | | | | | | |
| **Preventative Health Exams:** Date of last: | | | | | | Thorough health exam: | | | | | | | | | | | | | | | Pap Smear: | | | | | | Mammogram: | | | | | | | | Colonoscopy: | | | | |
| allergies/intolerance and reactions to all medications and other known allergies See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | Reaction: | | | | | | 2. | | | | | | | | | | Reaction: | | | | | | | | 3. | | | | | | | | | | Reaction: | | | |
| Surgical History and date See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | Date: | | | | | | | | | 2. | | | | | | | | | | | | | | | | | | Date: | | |
| 3. | | | | | | | | | | Date: | | | | | | | | | 4. | | | | | | | | | | | | | | | | | | Date: | | |
| Hospitalizations and date (including Pregnancies) See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | Date: | | | | | | | | | 2. | | | | | | | | | | | | | | | | | | Date: | | |
| 3. | | | | | | | | | | Date: | | | | | | | | | 4. | | | | | | | | | | | | | | | | | | Date: | | |
| Family history (please indicate relationship – i.e. father or mother – OR “n/a”) See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes: | | | | | | | | | High Blood Pressure: | | | | | | | | | | | | | | | | | | Heart Disease: | | | | | | | | | | | | |
| Alcoholism: | | | | | | | | | Stroke: | | | | | | | | | | | | | | | | | | Mental Illness: | | | | | | | | | | | | |
| Cancer: | | | | | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social History (please answer accordingly or write yes or no) See back  See attatched | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer Name: | | | | | | | | | Employment Status: Full-Time Part-Time  Self Employed Retired  Not Employed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Status: Full-Time Part-Time Not a Student | | | | | | | | | | | | | | Marital Status: | | | | | | | | | | Sexually Active: | | | | | | | | Religion: | | | | | | | |
| Do you Smoke? | Have you ever? | | | | | | | | Packs per day? | | | | | | | | | | | | | How many years? | | | | | | | | | Year quit? | | | | | | | | |
| Do you Chew? | Have you ever? | | | | | | | | Cans per day? | | | | | | | | | | | | | Cans per week? | | | | | | | | | Year quit? | | | | | | | | |
| Alcohol Use? | Have you ever? | | | | | | | | How often? | | | | | | | | | | | Drug Use? | | | Do you use Marijuana? | | | | | | | | | | | | | | | Card? | |
| **Date of last vaccine:** | Flu: | | | Tetanus: | | | | | | | | | | Pnuemovax: | | | | | | | | | Hep B or A: | | | | | | | | | | | Shingles: | | | | | |
| Signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Signature: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | |

# 