



Please fill this form out in print and give it to the nurse when you are called back to be seen by the physician.

Patient name: _____ Date of birth: _____ Age: _____

Reason for today's visit: _____

Who is your primary care physician? _____

Height? _____ Weight? _____

If in pain, location? _____ Severity level: 1 2 3 4 5 6 7 8 9 10 Duration: _____
(1 = the least pain)

If this is an injury, did it occur at work? Yes No

Have you received a tetanus shot / vaccine within the last 5 years? Yes No

List any allergies to medications or foods: _____

Please list any medications you are currently taking and the dosages:

Name of medication	Dosage and how often the medication is taken

Please list any surgeries you have had:

Please list any medical condition that you have or have had in the past (ex. high blood pressure, high cholesterol, diabetes, asthma, lupus, heart disease, reflux, gall stones, kidney stones, kidney disease, depression, anxiety, etc.):

Do you smoke? Yes No If yes, how much? ___ pack(s) per day.

Do you drink alcohol? Yes No If yes, how often and how much? _____

Are you pregnant? Yes No Date of your last menstrual cycle: _____

I, to the best of my ability, have answered all of the questions above truthfully.

Signature of patient or responsible party

Date