Patient Name ________________________________ **Date** ____________________

Personal Health – Please circle all that apply to YOU

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Depression	Heart disease
Breast Lump	Bronchitis	Bulimia	Cancer	Fibromyalgia	Chicken pox	Gout	Measles
Emphysema	Epilepsy	Fractures	Glaucoma	Cataracts	Gonorrhea	Liver disease	Parkinson's
Hepatitis	Hernia	Herniated Disc	Herpes	Goiter	Kidney disease	Pacemaker	Thyroid
Headaches	Miscarriage	Mono	M.S.	High Cholesterol	Osteoporosis	Stroke	Diabetes
Migraines	Polio	Prostate	Prosthesis	Mumps	Rheumatoid	Whooping Cough	
Pneumonia	Tuberculosis	Tumors	Typhoid	Implants	V.D.	Bleeding	
Chronic Fatigue	Tonsillitis	High Blood Pressure		Ulcers	Asthma	Other___________________	

Family Health – Please circle all that apply to your Family members

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Depression	Heart disease
Breast Lump	Bronchitis	Bulimia	Cancer	Fibromyalgia	Chicken pox	Gout	Measles
Emphysema	Epilepsy	Fractures	Glaucoma	Cataracts	Gonorrhea	Liver disease	Parkinson's
Hepatitis	Hernia	Herniated Disc	Herpes	Goiter	Kidney disease	Pacemaker	Thyroid
Headaches	Miscarriage	Mono	M.S.	High Cholesterol	Osteoporosis	Stroke	Diabetes
Migraines	Polio	Prostate	Prosthesis	Mumps	Rheumatoid	Whooping Cough	
Pneumonia	Tuberculosis	Tumors	Typhoid	Implants	V.D.	Bleeding	
Chronic Fatigue	Tonsillitis	High Blood Pressure		Ulcers	Asthma	Other___________________	

Please list all of your previous surgeries and dates.

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List ALL medications and supplements you are currently taking.

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Women only: Pregnant?____ Date of last menstrual cycle?______________________

All the above questions have been answered accurately and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office.

Patient Signature____Date___________________

Guardian Authorizing Care____Date___________________

Doctor Signature ____ **Date** __________________

IF YOU WERE IN AN AUTOMOBILE ACCIDENT, PLEASE COMPLETE THE ACCIDENTAL INJURY QUESTIONNAIRE