Information For Your Physician

*Complete **BOTH** sides in blue or black ink only*

Referring Physicians Name: _____

Address, City, State and Zip Code: _____

Please answer the following questions:

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Current Age:** _____ **Place of Birth:** _____

Height: _____ **Weight:** _____

Race or Nationality: _____

Are you employed? ☐ **Yes** ☐ **No** ☐ **Retired** **If yes, what is your occupation?** _____

Have you traveled outside of the USA and Canada in the past 5 years? ☐ **Yes** ☐ **No**

If yes, where? _____

Current Medications:

Name of Medication	Dosage (mg)	Frequency (once, twice, etc. per day)

Please check illnesses or conditions which you have had:

☐	Asthma	☐	Cancer	☐	Bleeding Tendencies	☐	Diabetes
☐	Glaucoma	☐	HIV	☐	Heart Trouble	☐	Hepatitis
☐	Kidney Disease	☐	Jaundice	☐	High Blood Pressure	☐	Nervous Disorder
☐	Pneumonia	☐	Stroke/TIA	☐	Rheumatic Fever	☐	Tuberculosis
☐	Hypothyroidism	☐	Sleep Apnea	☐	Reflux/Peptic Ulcer	☐	Blood Clots
☐	Obesity	☐	Elevated Cholesterol	☐	TURP	☐	

Other: _____

Have you ever had an allergic reaction to any medication? ☐ **Yes** ☐ **No**

If yes, which medication and what type of reaction:

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Have you ever had a latex allergy? ☐ **Yes** ☐ **No**

Have you ever had a tape allergy? ☐ **Yes** ☐ **No**

Have you ever had an allergic reaction to X-ray contrast dye? ☐ **Yes** ☐ **No**

If yes, please describe: _____

TURN OVER

Previous Operations (please list procedure and year):

Have you ever had any serious injuries, broken bones or hospitalizations? ☐ **Yes** ☐ **No**

If yes, please list with year: _____

_____

	Living	Present Age or age at death	Significant health problems or cause of death
Mother	☐ **Yes** ☐ **No**		
Father	☐ **Yes** ☐ **No**		
Spouse/Domestic Partner	☐ **Yes** ☐ **No**		

Please check illnesses which have occurred in any of your blood relatives:

_____ **Kidney Disease** _____ **Diabetes** _____ **High Blood Pressure** _____ **Nervous Disorder**
_____ **Cancer** _____ **Heart Disease** _____ **Bleeding Tendencies** _____ **Stroke**

	Number Living	Number Non-Living	Significant Health Problems	Cause of death
Brother				
Sister				
Son(s)				
Daughter(s)				

	Never	Now	In the Past	How much each day/week?	Per Occasion?	When did you quit?
Alcohol Use						
Tobacco Use						
Recreational Drug Use						

Caffeine Use	Soda	Tea	Coffee
How much per day?			
Occasional			

What type of physical activities do you perform (including Yoga, Tai Chi, etc)? _____

_____

Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)?

_____

_____

Please check the disease against which you have immunized:

	Polio		**Hepatitis A**		**Pneumoccal Pneumonia**		**Measles**
	Tetnus		**Hepatitis B**		**Rubella** (German Measles)		**Influenza**