

Last	First	Middle Initial
Medical Record Number (Place patient label here)		

Instructions: Please complete both sides of this form in black ink.

General Info	Name _____ Birth Date ____/____/____ <small style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> First MI Last </small> Previous Name _____ Preferred Name: _____ <small style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> First MI Last </small> Primary Phone (____) _____ - _____ Secondary Phone (____) _____ - _____ Country of Origin U.S./ _____ Gender (Circle one): Male Female Transgendered Person to notify in case of emergency: _____ <small style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> First MI Last </small> Phone (____) _____ - _____ Relationship to you _____																														
Medications	Please list current prescription and non-prescription medications, vitamins, supplements, home remedies, and herbs: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Medication/Vitamin/Other</th> <th style="width: 20%;">Dose</th> <th style="width: 10%;">Times per Day</th> <th style="width: 30%;">Medication/Vitamin/Other</th> <th style="width: 20%;">Dose</th> <th style="width: 10%;">Times per Day</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> None</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Medication/Vitamin/Other	Dose	Times per Day	Medication/Vitamin/Other	Dose	Times per Day	<input type="checkbox"/> None																							
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<input type="checkbox"/> None																															
Allergies	Please list all allergies or reactions to medicines/foods/seasonal/other agents: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Medicine/Food/Seasonal/Other Agent</th> <th style="width: 40%;">Reaction or Side Effect</th> <th style="width: 30%;">Medicine/Food/Seasonal/Other Agent</th> <th style="width: 40%;">Reaction or Side Effect</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> None</td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Medicine/Food/Seasonal/Other Agent	Reaction or Side Effect	Medicine/Food/Seasonal/Other Agent	Reaction or Side Effect	<input type="checkbox"/> None																									
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Functional	Do you need help understanding written or spoken health information? Yes No Do you have any special religious or cultural needs? Yes No If yes, please explain: _____ Do you have any special learning or communication needs? Yes No If yes, please explain: _____ Do you have any conditions or disabilities that limit your physical activities? Yes No If yes, please explain: _____																														
Social	Do you smoke/use tobacco? Yes No If yes, list quantity/type in typical day: _____ Do you drink alcohol? Yes No If yes, list quantity in typical week: _____ Do you use recreational drugs? Yes No Are you currently sexually active? Yes No If yes: Do you regularly use condoms? Yes No Number of sexual partners in the past year? _____ Partners are: Male Female Both																														
Nutrition	Do you eat a well-balanced diet? Yes No Do you feel you need to change your diet? Yes No Are you satisfied with your weight? Yes No																														

