



Who is responsible for your account? \_\_\_\_\_  
Relationship To Patient: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Health History**

What is the reason for your visit today?: \_\_\_\_\_  
\_\_\_\_\_

Is this a current health condition? : \_\_\_\_\_  
\_\_\_\_\_

What treatment have you receive in the past for your visit today? Medications / Surgrey /  
Physical Threapy / None / Other: \_\_\_\_\_

Names and Addresses for other doctors who have treated you in the past for your current  
condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Last:  
Physical Exam: \_\_\_\_\_ Spinal X-Ray: \_\_\_\_\_ Spinal Exam: \_\_\_\_\_

Please Indicate if you have had any of the following by circling "Yes" or "No":

Alcoholism	Yes	No	Fever (Prolonged)	Yes	No
Aids/HIV	Yes	No	Frequent Colds	Yes	No
Allergy Shots	Yes	No	Glaucoma	Yes	No
Anemia	Yes	No	Gaiter	Yes	No
Anorexia/Bulimia	Yes	No	Gout	Yes	No
Appendicitis	Yes	No	Hearing Loss	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No
Asthma	Yes	No	Hemorrhoids	Yes	No
Bead Wetting	Yes	No	Hepatitis	Yes	No
Bleeding Disorders	Yes	No	Hernia	Yes	No
Bronchitis	Yes	No	Herniated Disc	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Chemical Dependency	Yes	No	High Cholesterol	Yes	No
Chicken Pox	Yes	No	Infertility	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Difficulty Breathing	Yes	No	Liver Disease	Yes	No
Dizziness	Yes	No	Lower back Pain	Yes	No
Emphysema	Yes	No	Measles	Yes	No

Epilepsy	Yes	No	Mid back Pain	Yes	No		
Headaches	Yes	No	Migraines	Yes	No		
Mononucleosis	Yes	No	Thyroid Problems			Yes	No
Multiple Sclerosis	Yes	No	Tiredness			Yes	No
Mumps	Yes	No	TMJ (Jaw)			Yes	No
Numbness	Yes	No	Tremors			Yes	No
Osteoarthritis	Yes	No	Tuberculosis			Yes	No
Osteoporosis	Yes	No	Tumors or Growths			Yes	No
Pacemaker	Yes	No	Typhoid Fever			Yes	No
Parkinson's	Yes	No	Ulcers			Yes	No
Pinched Nerve	Yes	No	Whooping Cough			Yes	No
Pneumonia	Yes	No	Vision Problems			Yes	No
Polio	Yes	No					
Prostate Problem	Yes	No	Women Only:				
Prosthesis	Yes	No					
Psychiatric Care	Yes	No	Hysterectomy			Yes	No
Rheumatic Fever	Yes	No	Miscarriage			Yes	No
Rheumatoid Arthritis	Yes	No	Menopause			Yes	No
Ringing In Ears	Yes	No	Premenstrual Syndrome			Yes	No
Scarlet Fever	Yes	No	Irregular Menes			Yes	No
Sinus Infections	Yes	No	Cramps			Yes	No
STD's	Yes	No	Breast Problems			Yes	No
Stroke	Yes	No	Pregnant			Yes	No
			Date Due	_____			

If you have had any other medical problem that was not listed, Please, list below: \_\_\_\_\_

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Please, list the date along with any Surgeries or Injuries you have had in the past: \_\_\_\_\_

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Please, List your current medications you are taking today: \_\_\_\_\_

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Please, List if you have any allergies: \_\_\_\_\_

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