For OFFICE USE ONLY- **This form will NOT be a part of your permanent Electronic Medical Record.**

Wt:_____Ht:_____

Temp:_____

BP:_____/_____

Pulse:_____Resp:_____

You will be required to present your Current insurance card at each visit. Your insurance co-payment is due at the time of your visit. Thank you.

Today's Visit

Name: _____ Date: _____ DOB:_____

Type of Insurance:_____

Do You Smoke? Yes No How many cigarettes per day?_____

Please describe the main reason for today's visit:_____
_____
_____

Have you received any treatments, surgeries or medications from any other doctors since your last visit?
Yes No If yes, please describe:_____
_____
_____

Have any of your first relatives (mother, father, sisters, brothers) developed any serious illnesses since your last visit? Yes No If yes, please describe:_____
_____
_____

Have you experienced any allergies or adverse reactions to any medications since your last visit?
Yes No If yes, please describe: _____
_____

Have you changed your lifestyle habits (diet, exercise, tobacco, or alcohol usage) since your last visit?
Yes No If yes, please describe: _____
_____

List all medications (including over the counter & herbal) you are currently taking:

Medication	Dosage	Frequency