

Date ____/____/____

File today's visit with Insurance? Yes/ No

Patient Name _____ Date of Birth ____/____/____ Age _____

Gender M/F

Primary Care Physician: _____ **PCP Phone** _____

Please initial here _____ if you would like us to fax today's notes to your primary care physician.

Who referred you to us? _____

Preferred Pharmacy (Name and Location) _____

Reason for Today's Visit

How long have you had this problem? _____

How have you been treating it? (Doctor, Medications, etc.)

Is this an injury? Yes / No Car / Work / Other

Date of Injury ____/____/____

Time of injury ____:____

State injury occurred _____

Place of accident _____

How did the accident happen?

If work accident: Contact Name: _____ Phone #: _____

Do you have any drug allergies? Yes (list below) No

What medical conditions have you been diagnosed with in the past?

Disease **Date diagnosed** **Disease** **Date diagnosed**

What surgeries have you had in the past?

Surgery **Date** **Surgery** **Date**

Current prescription and/or over the counter medication(s)

Tobacco Use: Yes/No

Alcohol Use: Yes/No