

ALLERGY DATA BASE & HEALTH HISTORY

Please complete the following questionnaire legibly and **COMPLETELY**. This form will become the beginning of your chart, and will help the doctor to determine the cause of your problems. **ALL ITEMS MUST BE COMPLETED.**

Patient's Name: _____ Date this form completed: _____
(LAST) (FIRST) (MIDDLE)

Referred by: _____ Date office visit: _____

Patient's Nickname: _____ Patient's personal physician: _____

Address _____ Sex _____ Age _____
(CITY) (STATE) (ZIP) Date of Birth _____

Home Phone () _____ Bus. Phone () _____ Patient Occupation _____

Mother's Occupation _____ Father's Occupation _____

Marital Status (please circle): single married divorced separated widowed

If patient is a child, marital status of parent(s): single married divorced separated widowed

Last school grade completed by patient: _____ If child, lives with: _____

Mother's Name: _____ Father's Name: _____

Name of individual responsible for bill: _____

(STREET) (CITY) (STATE) (ZIP)

Employer: _____

Ins. Co. _____ If Medicare, # _____

Certificate/Policy # _____

SYMPTOMS/PROBLEMS:

Concisely list your symptoms/problems, i.e.: Why did you come to this office? What is bothering you? Explain if there is a pattern to the symptoms. Date symptoms/problems first recognized by patient. Score them 1-5. 1 = least bothersome, 5 = most bothersome.

MEDICATIONS

A. List any medications, their specific names, dosage, and how often currently taken. (Show brand names)

B. List any vitamin, mineral or nutritional supplements, their specific names, dosage, and how often currently taken. (Show brand names)

Please complete all forms and return them prior to your scheduled appointment.

Please attach a photo of yourself

