Patient Label	Interpreter or Assistive Services
	☐Interpreter or assistive services used during visit ☐ Client Declined Name:_____ ID#:_____ Signature:_____ Title:_____ (if in person)

ALLERGIES: ☐Food ☐Drug ☐Latex ☐Insects ☐Seasonal Describe: _____

CHECK IF YOU OR ANY FAMILY MEMBER HAVE THESE:	YOU	FAMILY		YOU	FAMILY	OFFICE USE ONLY
1. Anemia/sickle cell or trait	☐	☐	18. Epilepsy/Seizures	☐	☐	
2. Blood clots (legs or lungs)	☐	☐	19. Intellectual Disability/Learning Problems	☐	☐	
3. Blood disease or bleeding	☐	☐	20. Migraine Headaches	☐	☐	
4. Heart problems or murmurs	☐	☐	21. Stroke	☐		
5. High Blood Pressure	☐	☐	22. Diabetes	☐	☐	
6. Asthma or bronchitis	☐		23. Thyroid Problems	☐		
7. Tuberculosis/other lung problem	☐	☐	24. Bladder/Kidney Problems	☐		
8. Throat Problems	☐	☐	25. Genitourinary Problems	☐	☐	
9. Arthritis	☐		26. Deafness/Ear Problems/Tubes	☐		
10. Bone Problems	☐		27. Vision /Eye Problems	☐	☐	
11. Dental Problems	☐		28. Birth Defects	☐	☐	
12. Muscle/Joint Problems	☐		29. Genetic Diseases	☐	☐	
13. Skin Problems	☐		30. Cancer	☐	☐	
14. Diarrhea/Constipation/Bowel Problem	☐		31. Organ Transplant	☐		
15. Eating of non-food items	☐		32. HIV/Sexually Transmitted Infection	☐		
16. Feeding problems/Special Diet	☐		33. Mental Illness/Depression/ Depression after birth	☐	☐	
17. Gall Bladder Problems	☐		34. Suicide/thoughts/attempt	☐	☐	
18. Hepatitis or liver disease	☐	☐	35. Other_____	☐	☐	

G____P____A____ LMP: _____ If Pregnant, EDD: _____ Breastfeeding: ☐YES ☐NO Birth Control Method:_____

Have you ever been hospitalized? ☐YES ☐NO If YES; List dates and why_____

Do you drink alcohol/beer/wine/liquor? ☐YES ☐NO If YES, how much? _____

Do you use cigarettes/tobacco products? ☐YES ☐NO If YES, how much? _____ Quit Now referral? ☐YES ☐NO

Do you use other drugs? ☐YES ☐NO If YES, what? _____

Do you have any tattoos/body art/body piercings/traditional or tribal scars or markings? ☐YES ☐NO Describe: _____

_____

TNF Alpha Blockers? ☐YES ☐NO List any other medications: _____

Do you use any traditional herbs or remedies? ☐YES ☐NO If YES, what and how often? _____

Current Occupation/School: _____

Do you live in a ☐house ☐apartment ☐mobile home ☐hotel/motel ☐shelter ☐other (specify)_____? Number of persons living there: ____

Signature of person completing form: _____ **Date:** _____