

Patient Label

CHECK BELOW IF YOU OR ANY FAMILY MEMBER HAVE THESE:

	YOU	FAMILY		YOU	FAMILY	OFFICE USE ONLY
1. Allergies (food/drug/latex/insects/seasonal)			19. Genetic Diseases			
2. Anemia (low blood iron)/sickle cell or trait			20. Heart Problems/Murmurs			
3. Asthma or bronchitis			21. Hepatitis or liver disease			
4. Arthritis			22. High blood pressure			
5. Birth Defects			23. HIV/Sexually Transmitted Infection			
6. Bladder/Kidney Problems			24. Intellectual disability/Learning problems			
7. Blood clots (legs or lungs)			25. Mental illness/Depression/Depression after birth			
8. Blood disease or bleeding			26. Migraine headache			
9. Bone problems			27. Muscle/Joint problems			
10. Cancer			29. Organ Transplant			
11. Deafness/Ear problems/Tubes			29. Skin problems			
12. Dental Problems			30. Stroke			
13. Diabetes (sugar)			31. Suicide/thoughts/attempt			
14. Diarrhea/Constipation/Bowel Problem			32. Thyroid problems			
15. Eating of non-food items			33. Throat problems			
16. Epilepsy/Seizures			34. Tuberculosis/other lung problem			
17. Feeding Problems/Special Diet			35. Vision/Eye problem			
18. Gall Bladder Problems			36. 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 house ___ apartment ___ mobile home ___ motel ___ shelter ___ other ___? Number of persons living there: _____

Signature of person completing form: _____

Date: _____