

Print the form, complete the information and give it to the clinic's receptionist.

| | | | |
|--|-----------------------------|------------------------------|--|
| Patient Name: | | Date: | |
| Patient Date of Birth: | | Patient age: | |
| Nearest relative not living with you: | | Phone: | |
| How did you learn of this clinic? | | | |
| For what problem are you being seen today? | | | |
| | | | |
| | | | |
| Other Doctor seen for this condition | | | |
| How long have you had this problem? | | | |
| List all medications you are currently taking (prescription or non-prescription) | 1. | 4. | |
| | 2. | 5. | |
| | 3. | 6. | |
| How much aspirin do you take per week | | | |
| List all medications to which you are allergic | 1. | 4. | |
| | 2. | 5. | |
| | 3. | 6. | |
| Have you ever had local anesthetic (doctor, dentist)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Did you have any abnormal reactions? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Do you have any bleeding disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Do you take blood thinners? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Do you smoke? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Packs/day: <input type="text"/> How long: <input type="text"/> |
| Do you drink alcohol of any type? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | How often: <input type="text"/> |
| Do you have a pacemaker? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |

Have you or anyone in your family had or have any of these problems?

| PROBLEM | PATIENT | FAMILY |
|---------------------------------------|---|---|
| GLAUCOMA | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HEART TROUBLE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ABNORMAL EKG (HEART TEST) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BLOOD VESSEL DISEASE (PHLEBITIS) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BLOOD THINNERS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ASTHMA LUNG DISEASE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| TUBERCULOSIS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ABNORMAL CHEST X-RAY | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ABNORMAL BLEEDING | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BLOOD DISEASE (ANEMIA) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BLOOD TRANSFUSION | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| WHEN: | | |
| ARE YOU HIV POSITIVE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DIABETES | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CONTROLLED BY: | <input type="checkbox"/> Diet <input type="checkbox"/> Exercise | <input type="checkbox"/> Diet <input type="checkbox"/> Exercise |
| JAUNDICE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HEPATITIS OR MONONUCLEOSIS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ULCERS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| STOMACH PROBLEMS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| KIDNEY DESEASE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ARTHRITIS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BACK OR NECK PROBLEMS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| NUMBNESS OR TINGLING | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| WHEN: | | |
| WHERE: | | |
| SEIZURES | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| FAINTING | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| PARALYSIS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| STROKE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ABNORMAL EEG (BRAIN TEST) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DEPRESSION | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BAD NERVES | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| INSOMNIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HEADACHES | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| FREQUENT INFECTIONS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DRY SKIN OR SKIN RASH | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIVES OR ITCHING OF THE SKIN | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EXCESSIVE SWEATING | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| NOSE BLEEDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EXCESSIVE BLEEDING AFTER CUTTING SKIN | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EASY BRUISING | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SKIN CANCER | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BCCA (BASAL CELL CARCINOMA) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SCCA (SQUAMOUS CELL CARCINOMA) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MALIGNANT MELANOMA | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HAVE YOU HAD A BAD MOLE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Complete pages 1 and 2 of the questionnaire.