Patient Name:_____ Date:_____ Acct. #_____

Insurance Required Yearly Update

Please Check Any of Following For Which You Have Been Or Are Being Treated.

❑ Diabeties	❑ High Cholesterol	❑ Thyroid	❑ Renal Disease
❑ Hypertension	❑ Anemia	❑ Epilepsy	❑ Hepatitis
❑ Cerebral Accident	❑ Asthma	❑ Polio	❑ Venereal Disease
❑ Cardiac Disease	❑ Emphysema	❑ Cerebral Palsy	❑ AIDS or HIV
❑ PVD	❑ Tuberculosis	❑ Muscular Dystrophy	❑ Hemophilia
❑ Phlebitis	❑ Arthritis	❑ Neurological Disease	Other (Please State)
❑ Scarlet Fever	❑ Gout	❑ Gastrointestinal	
❑ Rheumatic Fever	❑ Heart attack	❑ Cancer	

Family History

Please List any significant health conditions for blood relatives:

Mother:_____ Father:_____ Siblings:_____ Children:_____

Drug Allergies (Circle All That Apply)

NONE	Tetracycline	Aspirin	Adhesives	Cortisone	Penicillin
Novocain	Codeine	Barbiturates	Sulfa	Caffeine	OTHER

Current Medications Please List

NONE				

Social History (Circle All That Apply)

Alcohol	Caffeine	Recreational Drugs	Smoker NO YES FORMER PACKS PER DAY _____

Review of Systems (Circle All That Apply)

GENERAL:	Weight loss	Fever	**HEMATOLOGIC:**		Abnormal bleeding
VASCULAR	Chest pain	Varicose veins	Toes feel cold	Calf pain with activity	Swelling in feet or legs
RESPIRATORY:	Cough	Wheezing	**GASTROINTESTINAL**		ulcers/acid reflux
SKIN:	Rashes	Open Sores	**ENDOCRINE:**		Hot or cold intolerance
NEUROLOGICAL	Burning	Loss of sensation	Numbness or tingling		
MUSCULOSKELETAL	Feeling unstable	Restricted motion	Muscle pain or weakness	Tendon tear or strain	Difficulty walking
	Joint pain or swelling		turning/ twisting of ankle	Low back pain/injury	