Male____Female____ Marital Status:_____
If a minor, name of parent or guardian:_____
Social Security Number:
E-mail:_____
Occupation:_____
Insurance Name: _____
Family Doctor:_____

GENERAL HEALTH: **(Circle conditions that apply to you)**

Allergy: (Medications/Environmental) - _____N/A
Cardiovascular: (Heart/Blood Vessel Disease) - High Blood Pressure, Stroke, other_____N/A
Constitutional: (Body Symptoms) - Dizziness, Weight change, fever, other_____N/A
Endocrine: (Metabolic Conditions) - Diabetes, Cholesterol, Thyroid, other_____N/A
Gastrointestinal: (Stomach/Intestine) - Gastritis, Constipation, Diarrhea, other_____N/A
Genitourinary: (Genital/Urinary organs) - STD, Kidney Stones, other_____N/A
Head: (Ear, Nose, Throat) - Ear infection, Sinus, Headaches, other_____N/A
Hematologic/Lymphatic: (Blood/Lymph) - Anemia, Leukemia, other_____N/A
Immunologic: (Immune System) - AIDS, Herpes, other_____N/A
Integumentary: (Skin) - Rosacea, Lupus, other_____N/A
Musculoskelatal: (Muscles/Bones)- Arthritis, Down's Syndrome, Muscular Dystrophy, other_____N/A
Neurological: (Nerves) - Multiple Sclerosis, Bell's Palsey, Parkinson's, other_____N/A
Psychiatric: (Mental Disorders)- Alzheimer's, ADD, Depression, other_____N/A
Respiratory: (Breathing)- Asthma, COPD, TB, other_____N/A
Current
Medicines:_____
_____N/A

**PRIVACY PRACTICES (HIPAA)**: I hereby acknowledge that I have been given the opportunity to read and/or to have a copy of the Health Information Portability and Accountability Act of this office.

X_____