Patient Profile

Please print all information.

Last Name _____ First Name _____ MI_____

Date of Birth _____ Age _____ Social Security # _____

Home Address _____ City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____

Which number above would you prefer for communication with text or message? _____Home _____Cell

Email Address* _____

Place of Employment _____ Work Phone _____

Emergency Contact _____ Phone _____ Relation _____

May we disclose any information with your emergency contact? _____Yes _____No _____ Initials

Patient Health History

Medications currently taking

Medication	Dose	Frequency

Allergies to Medications _____

Family History (please place a checkmark in the column of the relative who was diagnosed, if any.)

Problem	Mother	Father	Sister	Brother	Grandmother	Grandfather
Diabetes						
Heart Attack						
Cancer						
Renal Failure						
Hypertension						
Stroke						
Obesity						
Arthritis						

Joint Replacement						

Medical History (Please check all that apply)

○ **Allergies**	○ **Degenerative Disk Disease**	○ **Menstrual irregularity**
○ **Anxiety**	○ **Fatigue**	○ **Metabolic Syndrome**
○ **Asthma**	○ **Fibromyalgia**	○ **Peripheral Edema**
○ **Breast Cancer**	○ **GERD**	○ **Peptic Ulcer**
○ **Cardiomyopathy**	○ **Gestational Disease**	○ **Pulmonary Embolism**
○ **Carpal Tunnel Syndrome**	○ **Glucose Intolerance**	○ **Sleep Apnea**
○ **Chest pain**	○ **Hypothyroidism**	○ **Sleeping Disorder**
○ **Chronic Back Pain**	○ **Hemorrhoids**	○ **Migraine Headaches**
○ **Congestive Heart Failure**	○ **Hypertension**	○ **Varicose Veins**
○ **CVA**	○ **Heartburn**	○ **Venous Insufficiency**
○ **Deep Venous Thrombosis**	○ **Joint Pain**	○ **Arthritis**
○ **Depression**	○ **Insomnia**	○
○ **Diabetes**	○ **Irritable Bowel Syndrome**	○

Surgical History: Please list

_____

_____

_____

How did you hear about us?

☐ ValueNews Newspaper Broken Arrow	☐ Referred by
☐ The Ledger Newspaper	☐ Sign on building
☐ ValPak	☐ Television
☐ Billboard	☐ Radio

Do you work out? _____ What Activities: _____

How much water do you drink in a typical day? _____

Are you pregnant or trying to get pregnant? _____ Type of birth control _____

Please list any diets and/or weight loss methods and <u>medications</u> you have tried including physican-supervised :

_____

_____

X_____ X _____

Signature of Patient or Guardian Date Signature of Physician/Staff

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