



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 _____

Email Address _____

Place of Employment _____ Work Phone _____

Emergency Contact _____ Phone _____ Relation _____

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)

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

Surgical History: Please list

How did you hear about us?

<input type="checkbox"/> ValueNews Newspaper Broken Arrow	<input type="checkbox"/> Referred by
<input type="checkbox"/> The Ledger Newspaper	<input type="checkbox"/> Sign on building
<input type="checkbox"/> ValPak	<input type="checkbox"/> Television
<input type="checkbox"/> Billboard	<input type="checkbox"/> 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 medications you have tried including physician-supervised :

X _____ X _____

Signature of Patient or Guardian

Date

Signature of Physician/Staff