



Adult Health History

PATIENT INFORMATION

(CONFIDENTIAL)

Today's Date _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell#: _____ Social Security #: _____

Fax #: _____ email: _____ Marital status: _____

Who to Contact in Case of Emergency: _____ Phone # _____

RESPONSIBLE PARTY

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ Driver's License #: _____

Birth Date: _____ Home Phone: _____ Cell Phone/Pager: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Social Security #: _____

MEDICAL HISTORY

Have you ever had any of the following medical problems?

Y N Allergies to any drugs	Y N Diabetes	Y N Phen-Fen Use present/past
Y N Any Hospital Stays	Y N Seizures / Epilepsy	Y N Tuberculosis
Y N Any Operations	Y N Handicaps / Disabilities	Y N Heart Murmurs
Y N Latex Allergy	Y N Cancer	Y N Kidney Problems
Y N Bleeding Problems	Y N Rheumatic / Scarlet Fever	Y N Developmentally Delayed
Y N Hearing Impairments	Y N Heart Defects	Y N Cerebral Palsy
Y N Asthma / Lung Problems	Y N Hepatitis / Liver problems	Y N WOMEN: Is there any possibility you could be pregnant?

Weight _____ Height _____

Please discuss any medical problems that you have/had: _____

Physician: _____ Phone Number: _____

Are you currently under the care of a physician: Yes ___ No ___ Date of Last Visit: _____

Please describe your current physical health: Excellent _____ Good _____ Poor _____

Please list all medications you are currently taking: _____

Please list any known Allergies, including allergies to medications: _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Rajeev Misra of any changes in my medical status at the earliest possible time.

Signature of Patient _____ Date _____

Reviewed by: _____ Date _____