



**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

220 S Palisade Dr., Suite 104

Santa Maria, Ca 93454

**REFERRAL** : Who referred you to our office?

\_\_\_\_\_

**CHIEF COMPLAINT**: Please describe the purpose of your visit today:

\_\_\_\_\_

**MEDICAL HISTORY**: Please list any diseases or medical conditions you have:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST SURGERIES**: Please list any surgeries you have had with approximate dates performed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**: Please list any allergies you have to medications, adhesives, or other:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**: Please list the medications and strengths you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ACCIDENTS**: Please list any serious type injuries you have had with the approximate age of occurrence:

\_\_\_\_\_

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**SOCIAL HISTORY:**

What is your Marital Status?    \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated

What type of work do you do? \_\_\_\_\_

Do you smoke?    \_\_\_ Never    \_\_\_ Quit ( \_\_\_\_\_ What Year & \_\_\_\_\_ Packs per day for \_\_\_\_\_ Years)  
                  \_\_\_ Current Smoker ( \_\_\_\_\_ Packs per day \_\_\_\_\_ Years)    Smokeless Tobacco? Yes or No

Do you drink alcohol?    \_\_\_ Never    \_\_\_ Occasionally    \_\_\_ Daily ( \_\_\_\_\_ How many?)  
                                  \_\_\_ Drinks per week

How often do you exercise? \_\_\_\_\_

What Type of Exercise? (circle) Aerobic    Strength Training    Yoga/Pilates    Walking/Running    Swimming    Biking

How long do you exercise? \_\_\_\_\_

Diet?    \_\_\_ No Restrictions    \_\_\_ Low Salt    \_\_\_ Low Cholesterol    \_\_\_ Low Fat    \_\_\_ Gluten Free

**FAMILY HISTORY** : Please check any of the following if it runs in your family:

\_\_\_ Allergies    \_\_\_ Cancer ( \_\_\_\_\_ What type?)    \_\_\_ Diabetes    \_\_\_ Heart Disease  
\_\_\_ Stroke    \_\_\_ Tuberculosis

Please tell us about your family:

**Father:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Mother:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Brother / Sister:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Brother / Sister:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Brother / Sister:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Son / Daughter:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Son / Daughter:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

**Son / Daughter:**    \_\_\_ Alive    \_\_\_ Deceased    \_\_\_ Age    Medical Conditions: \_\_\_\_\_

Thanks again for your time! We understand that you have a choice in your health care and appreciate that you have chosen our practice to serve you. If you have any suggestions as to how we could do this better, please do not hesitate to let the doctors or staff members know.

