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:

Patient Name: _____

Date of Birth: _____

Today's Date: _____

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.