## IDENTIFICATION DATA

Please print the following information:

Date _____ Email address _____

Name _____ Date of birth _____ Age _____ ❑ Male ❑ Female

Address _____ ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Cohabiting

City, State, Zip _____ Education _____ years Elementary _____ years High School

Hm. ph. _____ Cell ph. _____ Wk. ph. _____ _____ years College, Technical, Business, etc.

Employer _____ Address _____ Occupation _____

## MEDICAL HISTORY:

For each person below, follow the line across the page and enter their age and mark an X in those boxes which indicate their present state of health (good), (poor), or write in the cause and age at death. Then place an X in those boxes which correspond with any illnesses that they have ever had.

| | Age | Health: Good | Health: Poor | Cause and age at death | Alcoholism/drug addiction | Allergies or asthma | Anemia | Diabetes | Cancer or tumor | Epilepsy | Genetic disease | Heart trouble | Herpes | High blood pressure | Kidney or bladder trouble | Mental disorder | Rheumatism or arthritis | Stomach/duodenal ulcer | Thyroid disease | Tuberculosis | Gonorrhea/syphilis |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self: | | | | | | | | | | | | | | | | | | | | | |
| Father: | | | | | | | | | | | | | | | | | | | | | |
| Mother: | | | | | | | | | | | | | | | | | | | | | |
| Brothers or Sisters: | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| Mother's Mother: | | | | | | | | | | | | | | | | | | | | | |
| Mother's Father: | | | | | | | | | | | | | | | | | | | | | |
| Mother's Relatives, Other: | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| Father's Mother: | | | | | | | | | | | | | | | | | | | | | |
| Father's Father: | | | | | | | | | | | | | | | | | | | | | |
| Father's Relatives, Other: | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |

**Please list any other serious illnesses any of your blood relatives have had:** _____

**SELF: Mark an X in the box next to any of the following that you have now or have ever had.**

| | | | | |
|---|---|---|---|---|
| ❑ bad reaction to immunization | ❑ depression | ❑ liver disease | ❑ pneumonia | ❑ other serious illness/injury |
| ❑ bronchitis | ❑ diverticulosis | ❑ malaria | ❑ polio | ❑ _____ |
| ❑ chicken pox | ❑ eczema | ❑ measles | ❑ rheumatic fever | ❑ _____ |
| ❑ childhood hyperactivity | ❑ German measles | ❑ mononucleosis | ❑ scarlet fever | ❑ _____ |
| | ❑ hemorrhoids | ❑ mumps | ❑ tension/anxiety | ❑ _____ |
| | ❑ hernia | ❑ pancreatitis | ❑ yellow jaundice | |

**Major Hospitalizations:** If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

Check this box ❑ if you have had more than three such hospitalizations. (do not include normal pregnancies)

| | Year | Operation or Illness |
|---|---|---|
| 1st hospitalization | | |
| 2nd hospitalization | | |
| 3rd hospitalization | | |

**Names & ages of children** _____

**Women Only:**

Age at onset of menses _____ No. of miscarriages _____

Method of birth control _____ No. of abortions _____

No. of pregnancies _____ Age at menopause _____

Are you allergic to any medicines or other substances? If so, please indicate: _____

What medicines do you presently take, including supplements and nonprescription items? _____

Referred by: _____

Name & Address of nearest relative or friend in case of emergency:

Name _____ Relationship _____

Address _____ Phone _____

Parents' name(s), (if child) _____

**PAYMENT IS EXPECTED AT THE TIME OF SERVICES. THANK YOU.**