New Patient Forms

PLEASE PRINT AND FILL IN ALL THE BLANKS

Today's Date: _____

PATIENT NAME _____

EMAIL: _____DATE OF BIRTH _____

ADDRESS _____ SEX _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____

EMPLOYER/OCCUPATION _____

WORK ADDRESS _____

CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY CONTACT: _____

CONTACT PHONE NUMBER: _____

RELATIONSHIP TO YOU: _____

BODY SYMMETRYMD

Health History

HAVE YOU HAD OR DO YOU CURRENTLY… (please check all that apply)

	High blood pressure		Reduced sex drive
	Chest pain/angina		Blood disorder such as anemia
	Heart attack(s)		Bruise easily
	Irregular heart beat		Gallbladder trouble
	Cardiac pacemaker		Fainting spells
	Are you on dialysis?		Thyroid trouble
	Stomach ulcers		Diabetes
	History of breast cancer		Low blood sugar
	History of uterine cancer		Swollen ankles, arthritis, or joint disease
	History of ovarian cancer		Sleep apnea
	History of prostate cancer		Insomnia or poor sleep quality

ARE YOU CURRENTLY TAKING… (please check all that apply)

	Blood thinners		Blood pressure meds
	Sleep-inducing medications		Aspirin
	Cortisone		Ibuprofen or Tylenol
	Medications for acid reflux or GERD		Antihistamines/decongestants
	Prescription appetite suppressants (Adipex, phentermine, etc.)		Antidepressants or anxiety medications
	Thyroid meds		Muscle relaxants or tranquilizers
	Antibiotics		Insulin or diabetic meds

Health History

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO…

(please check all that apply)

	Local anesthetics
	Penicillin
	Other Antibiotics
	Aspirin
	Codeine or other narcotics
	Any other drug allergies?
	Latex

WOMEN…

	Could you possibly be pregnant?
	Are you currently on birth control?
	Date of your last menstrual period: _____
	Date of your last pap smear: _____
	Date of your last mammogram: _____

MEN…

	Date of your last prostate exam: _____
	Date of your last PSA test: _____

CURRENT HEIGHT _____ **CURRENT WEIGHT** _____

Do you consider yourself in good health? _____YES _____ NO

Any change in your health in the past year? _____ YES _____ NO

Are you under the care of a physician? _____ YES _____ NO

Have you ever been hospitalized? If so, please list dates and reasons for your Hospitalization:

_____

_____

_____

I certify that I have read and understand the questions in these forms; I acknowledge that I will have the opportunity to discuss my health history with my doctor. I will not hold my doctor or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of these forms.

SIGNATURE OF PATIENT _____

Consent to antibody testing: In the event of an accidental exposure to blood or other bodily fluids through needle stick, cut, mucous membrane contact, or the like, the undersigned consents to appropriate tests for the presence of Hepatitis B & C and HIV, which is the virus believed to cause AIDS. The patient will be informed of any positive results, and all such results will be treated as confidential by *Chimera Medical Services*. There is no charge to the patient.

SIGNATURE OF PATIENT _____

Current Meds/Supplements	Strength	Dose/Comments