Name: _____

Address: _____

_____

Home Phone: _____

Daytime Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Pharmacy: _____

Employer of Insurance Subscriber: _____

*** PLEASE PRESENT YOUR INSURANCE CARD AT THE FRONT DESK ***

YES	NO	
		Tired/Fatigue
		Weight change
		Appetite changing
		Sleeping difficulties or insomnia
		Fever/chills/night sweats
		Tendency to be too hot
		Tendency to be too cold
		Unexplained lumps/growths
		Frequent or severe headaches
		Dizziness, lightheadedness, vertigo
		Fainting spells
		Memory loss or confusion
		Numbness or a tingling sensation
		Visual problems
		Sinus drainage/congestion
		Allergies
		Ear or mouth problems
		Sores in your mouth
		Coughing spells
		Shortness of breath
		Chest pain or palpitations
		Heaviness or ache in your chest
		Swollen feet or ankles
		Breast mass or discharge

YES	NO	
		Difficulty swallowing
		Indigestion or heartburn
		Bloating, belching or excess gas
		Nausea or vomiting
		Abdominal pain
		Diarrhea or constipation
		Blood in your stool or black stool
		Urinary problems
		Sexual difficulties
		Vaginal discharge or bleeding
		Aching muscles or joints
		Swelling or stiffness in your joints
		Back or shoulder pain
		Recent skin rash or problem
		Changing moles
		Irritablity or mood swings
		Lonely or depressed
		Nervousness or anxiety
		Tatoo