

Patient Information

- **Full Name:** _____
 - **Date of Birth:** ___ / ___ / ____
 - **Gender:** Male Female Other Prefer not to say
 - **Phone Number:** _____
 - **Email Address:** _____
 - **Home Address:** _____
 - **Emergency Contact Name & Phone:** _____
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Insurance Information

- **Insurance Provider:** _____
 - **Policy Number:** _____
 - **Group Number:** _____
 - **Primary Policy Holder (if not patient):** _____
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Medical History

Do you currently or have you ever had the following? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congeestive Heart Failure | <input type="checkbox"/> Angina or Heart attack |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Diabetes (Last HbA1C_____) | <input type="checkbox"/> Asthma / Lung Conditions |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hyper- or Hypo-thyroid |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Currently on Blood Thinners | <input type="checkbox"/> Excessive bleeding when cut |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Infections or Diseases |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Currently on Dialysis |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Frequent Fainting |
| <input type="checkbox"/> Epilepsy (Seizures) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Cancer (type: _____) |
| <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Joint Replacement (Date: _____) | <input type="checkbox"/> Pregnant/ Nursing |
| <input type="checkbox"/> Bisphosonate | |

Other major illnesses: _____

Allergies Please List: _____

Surgeries / Hospitalizations:

Current Medications (Including over-the-counter):



Over the Counter Suppletments:

Primary Care Physician: _____

Specialists: _____

Lifestyle Information

- **Do you smoke?** Yes No
- **Do you drink alcohol?** Yes No
- **Do you exercise regularly?** Yes No
- **Occupation:** _____

Reason for Visit

Consent & Signature

I certify that the above information is true and complete to the best of my knowledge.

Patient / Guardian Signature: _____ **Date:** ____ / ____ / ____

Dr. Jason Wong
Dr. Russell Gornstein
Dr. Megan Leyva

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