PATIENT HEALTH AND HISTORY INFORMATION

Dr. Jennifer Stevens 760-730-1880 756 Grand Ave., Carlsbad, CA 92008

PERSONAL INFORMATION:

Name_____Date_____

Address_____City_____State_____Zip_____

Phone (Home) _____ (cell) _____ (work) _____

Email_____Birthdate_____Age_____Sex_____

Social Security No._____Driver's License No._____

Employer_____Occupation_____Years Employed_____

Employers Address_____City_____State_____Zip_____

How did you hear about us?_____Marital Status: M S W D No. of Children_____

Primary Language:_____ **Ethnicity:** _____Hispanic/Latino _____Not Hispanic/Latino _____Other ____Declined

Race: ____American Indian/Alaskan Native ____Asian ____Black/African ___Native Hawaiian/Pacific Islander ____Other Pacific Islander

___ White ____ Other: Please Specify_____ _____Declined

INSURANCE INFORMATION

Subscriber Name (Person who is the primary carrier of your insurance)_____Birthdate_____

Subscriber address if different than above_____

Subscriber's Employer_____

EMERGENCY CONTACT INFORMATION:

Name_____Phone_____

Name_____Phone_____

SURGERIES:

Have you ever had any surgeries? Please list all:_____

ALLERGIES:

MEDICATION: Please list any medications you are allergic to:_____

FOODS: Please list any foods you are allergic to:_____

SEASONAL/HAY FEVER/POLLEN: Please list:_____

CURRENT MEDICATIONS: Please list any medications you take:

NAME OF MEDICATION	**STRENGTH** (mg, etc.)	**DOSE** (1x/day, etc.)	**FORM** (pill, cap, etc.)

SOCIAL HISTORY: Please check all that apply

___ Caffeine ____Alcohol ____Chew Tobacco ____Exercise (How often?_____)

Smoking Tobacco : ___Everyday ____Sometimes ____Former smoker _____Date quit ____ I have NEVER smoked

(doctor use only)**BP**_____

PATIENT HEALTH AND HISTORY INFORMATION

Dr. Jennifer Stevens 760-730-1880 756 Grand Ave., Carlsbad, CA 92008

Patient Name_____Current Height_____Weight_____

SYMPTOMS: What symptoms are you having that bring you into our office today?_____

_____

PATIENT HEALTH HISTORY: Please check all that apply to YOU currently or in the past:

- ☐ Poor Circulation
- ☐ Hypertension
- ☐ Aortic Aneurism
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Jaw pain
- ☐ Swelling of legs
- ☐ Kidney Disease
- ☐ Burning /Frequent Urination
- ☐ Blood in urine
- ☐ Kidney Stones
- ☐ Lower side pain
- ☐ Stroke
- ☐ Seizures
- ☐ Head injury
- ☐ Brain Aneurysm
- ☐ Numbness
- ☐ Severe headaches
- ☐ Pinched nerves
- ☐ Parkinson's
- ☐ Carpal tunnel
- ☐ Vertigo/Dizziness
- ☐ Weight loss/gain
- ☐ Low energy level
- ☐ Difficulty sleeping
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Short breath
- ☐ Emphysema
- ☐ Cold/Flu
- ☐ Cough
- ☐ Wheezing
- ☐ Glaucoma
- ☐ Double vision
- ☐ Blurred vision
- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ Thyroid
- ☐ Diabetes
- ☐ Hair loss
- ☐ Menopausal
- ☐ Menstrual
- ☐ Hepatitis
- ☐ Blood clots
- ☐ Cancer
- ☐ Bruising
- ☐ Bleeding
- ☐ Fever, chills
- ☐ Sweating
- ☐ Hives
- ☐ Immune Disorder
- ☐ HIV/AIDS
- ☐ Allergy shots
- ☐ Cortisone use
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Sinus Infections
- ☐ Gall bladder problems
- ☐ Bowel problems
- ☐ Constipation
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Bloody stools
- ☐ Poor appetite
- ☐ Gout
- ☐ Arthritis
- ☐ Joint stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis
- ☐ Broken bones
- ☐ Joints replaced
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Back Pain
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Celiac Disease
- ☐ Cold extremities
- ☐ Cramps
- ☐ Digestion Problems
- ☐ Ears ring
- ☐ Excess Menstruation
- ☐ Eye pain or difficulties
- ☐ Fatigue
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ Hot flashes
- ☐ Interstitial cystitis
- ☐ Irregular heart beat
- ☐ Kidney infection
- ☐ Loss of balance
- ☐ Loss of memory
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lung problems
- ☐ Neck pain
- ☐ Nervousness
- ☐ Nose
- ☐ Other
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate trouble
- ☐ Sciatica
- ☐ Sleep problems
- ☐ Spinal curvatures
- ☐ Swollen ankles
- ☐ Swollen hands
- ☐ Swollen joints
- ☐ Tendonitis
- ☐ Varicose Veins
- ☐ Venereal disease

FAMILY HISTORY: Please list any medical conditions your family members have had or currently have:

Mother_____Father_____Grandmother_____

Grandfather_____Siblings_____Children_____