COMPREHENSIVE HEALTH INFORMATION FORM

DATE ______________________

NAME______________________________________ E-MAIL______________________

AGE ________ BIRTH DATE:______________________ [ ] Male [ ] Female

Who referred you to our practice? ______________________________

Who is your primary care physician? ______________________ What City? ______________

What is his/her phone number? ______________________

RACE: [ ] American Indian or Alaska Native [ ] Native Hawaiian [ ] White [ ] Other Pacific Islander
[ ] Black or African American [ ] Refused to Report/Unreported [ ] Asian [ ] Undefined

ETHNICITY:
[ ] Hispanic or Latino [ ] Not Hispanic or Latino

LANGUAGE ______________________________________

PHARMACY ______________________ CITY ______________ PHONE ______________

DATE OF INJURY ______________________ HEIGHT ____________ WEIGHT ____________

Do you have ALLERGIES to drugs, food or the environment?
[ ] NO [ ] Yes (List) ______________________________________

Do you have ALLERGIES TO NICKEL OR ANY OTHER METALS?
[ ] NO [ ] YES (List) ______________________________________

What PRESCRIPTION medications do you take? What are they for? [ ] None.

______________________ for ______________________

______________________ for ______________________

______________________ for ______________________

______________________ for ______________________

What OVER THE COUNTER medications, vitamins do you take? [ ] None

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Do you take ASPIRIN or any products containing aspirin? [ ] None [ ] Yes
[ ] Daily [ ] Only as Needed

Have you ever had ANY hand surgery? [ ] Yes [ ] No

HAND DOMINANCE: [ ] Right [ ] Left [ ] Ambidextrous

HOBBIES: ____

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OCCUPATION: ____