

ATLANTICENT

ASSOCIATES, P.A.

Last Name _____ First Name _____ Middle _____

DOB _____ Age: _____

Name of Referring Doctor _____

PERSONAL HISTORY (have you ever had one of the following):

Measles	YES NO	Hepatitis	YES NO
Chicken Pox	YES NO	Jaundice	YES NO
Pneumonia	YES NO	Kidney Disease	YES NO
Influenza (flu)	YES NO	Epilepsy or Seizures	YES NO
Heart Disease	YES NO	Diabetes	YES NO
High Blood Pressure	YES NO	Cancer (Type?)	YES NO
Circulation Problem	YES NO	Nervous Breakdown	YES NO
Blood or Bleeding Disorder	YES NO	Asthma or other Pulmonary Problem (Specify)	YES NO
Arthritis	YES NO	Frequent Headaches	YES NO
Other Bone or Joint Disease (Specify)	YES NO	Frequent Colds or Sore Throats	YES NO
Neuritis or Neuralgia	YES NO	Meningitis Tuberculosis	YES NO
Herpes or Cold Sores(Specify)	YES NO	Sexually Transmitted Disease(Type?)	YES NO
List any other Medical problems:		Thyroid Disease	YES NO

FAMILY HISTORY: Cancer YES NO Type _____; Hearing Loss YES NO; Diabetes YES NO; Heart Disease YES NO

List any Surgeries Below:

List any Allergies Below:

Do you have a prescription plan YES NO

Name & Phone of Pharmacy: _____

Alcoholic Beverages: Never ____, Barely ____, Moderate ____, Daily ____

Tobacco: Currently Smoking ____ packs daily; # of years ____; Never Smoked ____

Quit (what year) ____; # of years smoking ____; # packs daily ____

The confidentiality of your medical information is protected by law. This is strictly enforced.

DATE

SIGNATURE OF PATIENT/PARENT/GUARDIAN