PATIENT INFORMATION

PATIENT NAME:_____MALE:_____FEMALE:____
Last (Legal First) Middle Initial

ADDRESS:_____
Street PO Box or Apt. # City State Zip

HOME PHONE: (____)_____ MARITAL STATUS: M S D W

AGE:_____ DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

EMAIL ADDRESS:_____

How did you hear about our office?_____

PATIENT'S EMPLOYER:_____ WORK PHONE:_____

RESPONSIBLE PARTY / BILLING INFORMATION

NAME:_____ BIRTH DATE:_____

ADDRESS:_____ PHONE:_____
Street PO Box or Apt. # City State Zip

Consent to Evaluate and Treat: I certify that I have rights to and do give the staff at STEP Therapies, Inc, it's doctors, and paraprofessional staff members to evaluate and treat with tests, examinations, or treatment they feel is necessary for this minor.

Signed:_____ Relationship (parent/guardian, etc.):_____ Date:_____

NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU TO NOTIFY IN CASE OF EMERGENCY:

NAME:_____ RELATIONSHIP:_____ PHONE:_____

PATIENT HISTORY

Last Name First Name Middle Initial

Primary Care Physician: Dr. _____ Location:_____

Marital Status: M S D W SEP

Occupation:_____

Do you have any knows allergies (drug)? Yes___ No ___. If yes, Please list all known allergies: _____

Have you had treatment for this problem before? If so, what :_____

Please list all of you current medications (name, dosage, and frequency), as well as over the counter medications:

_____

_____

_____

Do you or have you ever smoked cigarettes, cigars or pipes? Yes ___ No ___. If Yes, how long?_____

If Yes, how many packs per day? _____Age you started:____ If you have quit smoking, when was it? ___Month ____Year

Do you or have you ever consumed alcohol? Yes ___ No ___. If Yes, how much & how often:_____

Scarlet Fever	Yes	No	High Blood Pressure	Yes	No	Skin Disorders	Yes	No
Measles	Yes	No	Heart Murmur	Yes	No	Tumor, Cancer, Cysts	Yes	No
German Measles	Yes	No	Dizziness/Fainting	Yes	No	Venereal Diseases	Yes	No
Rheumatic Fever	Yes	No	Weakness/Paralysis	Yes	No	Sugar in Urine	Yes	No
Mumps	Yes	No	Insomnia	Yes	No	Frequent Urination	Yes	No
Chicken Pox	Yes	No	Frequent Anxiety or	Yes	No	Pain in Urination	Yes	No
Malaria	Yes	No	Depression	Yes	No	**FEMALES ONLY**		
Tuberculosis	Yes	No	Recurrent Headaches	Yes	No	No. of Pregnancies	Yes	No
Gum or Tooth Problems	Yes	No	Recurrent Colds	Yes	No	Irregular Periods	Yes	No
Sinusitis	Yes	No	Gallbladder Disease	Yes	No	Severe Cramps	Yes	No
Eye Trouble	Yes	No	Bloody Stools	Yes	No	Excessive flow	Yes	No
Ear, Nose, Throat	Yes	No	Recurrent Diarrhea	Yes	No	**IMMUNIZATIONS**		
Head Injury	Yes	No	Jaundice	Yes	No	MMR-Measles/Mumps	Yes	No
Hay Fever/Allergies	Yes	No	Stomach Problems	Yes	No	Polio	Yes	No
Asthma	Yes	No	Recent Weight Gain/			DPT	Yes	No
Shortness of Breath	Yes	No	Weight Loss	Yes	No	Tetenus	Yes	No
Chest Pain/Pressure	Yes	No	Joint Disease	Yes	No	Flu Shot	Yes	No
Chronic Cough	Yes	No	Back Problems	Yes	No	Pneumovax	Yes	No
Rapid Heart Beat or			Sciatica	Yes	No	Mammogram	Yes	No
Palpitations	Yes	No	Neck Pain	Yes	No	Flexible Signoidoscopy		
			Other:_____			Or Procto Exam	Yes	No

List Surgeries & Dates:_____

Patient Signature:_____ Date Completed:_____