ROBERT POE MD

Date:_____

Patient Demographics

Name:_____
(First) (Middle) (Last)

DOB (mm/dd/yy):_____ **Social Security #**:_____

Address:_____

City_____ **State**:_____ **Zip Code:**_____

Mobile: (___)_____ **Home**: (___)_____ **Work**: (___)_____

Email address: _____ **Marital Status:**_____

Ethnicity ***(Please circle)***: Hispanic or NonHispanic **Preferred Language**:_____

Preferred Pharmacy:_____ **Location:**_____

Have you recently received either of the following vaccinations:

(Please circle) Influenza Pneumonia None **Month/Year:**_____

Race (please check one): _____American Indian _____Asian
_____Black or African American _____Caucasian
_____Native Hawaiian or Other Pacific Islander

Smoker: _____Never smoker _____Unknown if ever smoked
_____Former smoker _____Smoker, current status unknown Quit Date
_____Current every day smoker _____Current some day smoker ___/___/___
_____Heavy tobacco smoker _____Light tobacco smoker

Previous MRI or CT of the head or neck:

Where:_____
When:_____
Results:_____

Sex ***(Please circle)***: Male or Female **Height**:_____ **Weight**:_____

Emergency Contact info:

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Relationship to patient:_____ Phone:_____

Patient History

Chief Complaint:_____

Medication Allergies:_____

Primary Care Doctor:_____ **Referred by**:_____

Current Medications

Please feel free to use the back if needed

Regular Medications	Mg	# of times per day

Past Surgical History

Previous Surgeries	Surgeon/ Hospital	Year

Head, Neck, or Back injuries: _____**Date**:_____

Other serious injuries: _____**Date**:_____

If MAJOR SYMPTOMS ARE DUE TO INJURY ON JOB, PLEASE COMPLETE THE FOLLOWING

Date:_____ **Place**:_____

Describe accident:_____

Doctor consulted:_____

X-Rays taken (date & location):_____

First day out of work:_____ **Amount of days absent**:_____

Caseworker name:_____ **Phone #:** (___)_____

Past Medical History

Do you currently or have you previously experienced any of the following:

Please write year of onset

Asthma		High Blood Pressure	
Blood Disorder		Kidney Disease	
Cancer		Lung Cancer	
Chest Pain		Unconsciousness	
Diabetes		Venereal Disease	
Heart Disease		Mental Disorder	
Stomach Ulcers		Thyroid Disorder	
Hepatitis/ Jaundice			

Unusual Childhood illness:_____

Any other illness:_____

Family History

Do you have any blood relatives with the following:

Problem	YES	NO	Relationship
Hearing Loss			
High Blood Pressure			
Heart Disease			
Stroke			
Tuberculosis			
Diabetes			
Convulsion/ Epilepsy			
Cancer Type			
Birth Defect			
Type of defect			
Cleft Lip, ETC			
Type of cleft			
Other disease			
Type of disease			