The Grossgold Clinic

New Patient Profile

Please complete these pages as accurately and as completely as possible.
Use the "tab" key on your keyboard to move between fields.

Today's date: _____

Name: _____ (first) _____ (middle) _____ (last)

Sex: _____ Height: _____ Weight: _____

SS#: _____ Date of birth: _____ Marital status: _____

Home address: _____

City: _____ State: _____ Zip: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Home #: _____ OK to leave a message? _____ Work #: _____ OK to leave a message? _____

Mobile #: _____ OK to leave a message? _____ Email: _____ OK to leave a message? _____

Preferred method of contact: _____

Patient's employer: _____ Occupation: _____

Name of parents (if patient is a minor): _____

In case of emergency contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Tell us about you:

Your hobbies: _____ Your faith: _____

How did you find us: _____ Who referred you to us? _____

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Health Information (confidential)

PRESENT HEALTH CONCERNS: Please list three to five of your most important health concerns, in the order of their importance to you. (For example, #1 is most important and #3 is least important). The lines in this form are self-expanding — you are welcome to enter as much information as you feel is necessary.

Concern #1 - MAIN COMPLAINT	
How long have you had this problem?	
What makes it better?	
What makes it worse?	
What kinds of tests or exams have you had for it?	
What is the diagnosis?	
What kind of medications/supplements have you taken for it?	
Please elaborate, if necessary.	

Concern #2	
How long have you had this problem?	
What makes it better?	
What makes it worse?	
What kinds of tests or exams have you had for it?	
What is the diagnosis?	
What kind of medications/supplements have you taken for it?	
Please elaborate, if necessary.	

Concern #3	
How long have you had this problem?	
What makes it better?	
What makes it worse?	
What kinds of tests or exams have you had for it?	
What is the diagnosis?	
What kind of medications/supplements have you taken for it?	
Please elaborate, if necessary.	

MEDICAL SUMMARY: Please write a chronological history that summarizes your medical history in regards to the above concerns. **Example**: I was well until January 2012 when I had the flu. Since then, I have had daily headaches, etc..

YOUR MAJOR GOALS FOR THE FIRST VISIT: What you would like to accomplish on the first visit?

1) _____
2) _____
3) _____
4) _____

YOUR QUESTIONS: What questions do you have for today's visit?

_____
_____
_____

ALLERGIES: Please list all **food, environmental,** and/or **drug** allergies:

_____
_____

PHARMACY INFORMATION:

Name & address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

MEDICAL HISTORY: Please list all previous **medical procedures**, **surgeries**, **hospitalizations**, & **serious illnesses.**

Approximate date/ year	Surgery / hospitalizations / procedures / serious illnesses / injuries

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CURRENT MEDICATIONS: Please list the medications and/or supplements that you are currently taking, with dosages, including **prescription medications** (e.g., Prozac, atenolol, etc), **non-prescription medications** (e.g., aspirin, Tylenol, ibuprofen) and/or **health supplements** (e.g., vitamins, minerals, herbs).

NAME of medication or supplement, drugs, vitamins, herbs, minerals	**DOSE** in milligrams or grams (or number of capsules, tablets)	**FREQUENCY**: Times per day/ week/ month	**DURATION**: Been taking for how long?

DIET: Do you follow any particular diet regimens or restrictions?

EXERCISE: Do you exercise regularly? If YES—what do you do? If NO—what keeps you from exercising?

☐ Yes. What kind of exercise do you do?

☐ No. What keeps you from exercising?

HABITS and LIFESTYLE: Which of the following do you use?

☐ Current Smoker
☐ Former Smoker
☐ Alcohol
☐ Cola/soda
☐ Black tea
☐ Coffee
☐ Recreational drugs
☐ Prescription drugs

OTHER ADDITIONAL INFORMATION: