

Patient Name: _____ **Age:** _____ **Chart #:** _____

Doctor: (Please Circle One) BERGQUIST HIRSBRUNNER

ALLERGIES and reaction: NO KNOWN ALLERGIES

PCN _____ Sulfa _____ Latex _____ Other _____

Medications	Dose (mg)	Frequency (how often)	Reason for taking meds
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please circle ALL that apply:

Work Status: Full Time / Part Time / Retired / Unemployed / Homemaker / Disabled / Student

If student,

Name of School: _____ Sports Activities: _____

Type of Work: Primarily Seated / Light Duty / Manual Labor

Marital Status: Married / Single / Divorced / Widowed / Separated

Living Situation: With Spouse / Alone / With Parents / With Friend / Other: _____

Referring Physician or Clinic: _____

Family Doctor: _____ Pharmacy: _____

Please Circle Yes or No to each inquiry:

Personal Behavior History: Yes No Alcohol Use Yes No Tobacco Use	Family History: Yes No Diabetes Mellitus Yes No Cancer Yes No Heart Disease Yes No Hypertension Yes No Arthritis	Shoe Size: _____
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