

Teresa S. Stadler, M.D., F.A.C.S.M.



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PATIENT NAME: \_\_\_\_\_  
DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Sport: \_\_\_\_\_

Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

**INSURANCE:**

Primary Insurance: \_\_\_\_\_ Policyholder: \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Policyholder: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

**MEDICAL HISTORY** (check all that apply)

- |  |   |  |                                  |
|--|---|--|----------------------------------|
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Lung Problems   | <input type="checkbox"/> STDs    |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Currently Pregnant   | <input type="checkbox"/> Blood Clots     | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Polio           | <input type="checkbox"/> TB      |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Psychological   | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bladder       | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Recurrent       | <input type="checkbox"/> Disease |
| <input type="checkbox"/> Problems      | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Infections      | <input type="checkbox"/> Ulcers  |
| <input type="checkbox"/> Bleeding      | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Rheumatic Fever |                                  |
| <input type="checkbox"/> Disorders     | <input type="checkbox"/> Intestinal Disorders | <input type="checkbox"/> Scarlet Fever   |                                  |
| <input type="checkbox"/> Bowel         | <input type="checkbox"/> Kidney Disease       |  |                                  |
| <input type="checkbox"/> Problems      |   |  |                                  |

Other (please specify): \_\_\_\_\_

**DRUG ALLERGIES** (please list drug and reaction): \_\_\_\_\_

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**CURRENT MEDICATIONS** (list name, dosage, how long on medication): \_\_\_\_\_

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List all over the counter medications: \_\_\_\_\_

**PAST SURGICAL HISTORY** (list type of surgery, date and surgeon): \_\_\_\_\_

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**FAMILY HISTORY** (check all that apply):

\_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Tuberculosis  
\_\_\_\_\_ Kidney Disease \_\_\_\_\_ Arthritis Other (specify): \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Children: # \_\_\_\_\_ Do you live alone: \_\_\_\_\_ Do you consume alcohol: \_\_\_\_\_ If  
so, how much: \_\_\_\_\_ Currently Smoke: \_\_\_\_\_ If so, how  
much: \_\_\_\_\_ How long: \_\_\_\_\_

**REVIEW OF SYSTEMS** (please check symptoms experienced on a regular basis):

<i>General</i>	<i>Eyes</i>	<i>Throat</i>	<i>Gastrointestinal</i>
_____ Fever	_____ Blurring	_____ Soreness	_____ Nausea
_____ Night Sweat	_____ Eyestrain	_____ Hoarseness	_____ Vomiting
_____ Weight Gain	_____ Glasses/contacts	_____ Difficulty	_____ Belching
_____ Weight Loss	_____ Discharge	_____ Swallowing	_____ Constipation
			_____ Diarrhea
<i>Skin</i>	<i>Ears</i>	<i>Genitourinary</i>	<i>Neuromuscular</i>
_____ Rashes	_____ Deafness	_____ Pain	_____ Weakness
_____ Cyanosis	_____ Ringing	_____ Frequent	_____ Joint Pain
_____ (blush/tint)	_____ Pain	_____ Urination	_____ Tingling
_____ Jaundice	_____ Discharge	_____ Incontinence	_____ Deformities
<i>Head</i>	<i>Nose</i>	<i>Cardiovascular</i>	<i>Respiratory</i>
_____ Headache	_____ Sinusitis	_____ Chest Pain	_____ Chest Pain
_____ Fainting	_____ Obstruction	_____ Throbbing	_____ Difficulty
_____ Trauma		_____ Headaches	_____ Breathing
		_____ Faintness	_____ Bloody
		_____ Fluid/Swelling	_____ Sputum
		_____ Around	_____ Date of Last Chest
		_____ Extremities	_____ X-ray: _____

**FEMALE REPRODUCTIVE:**

Date of last exam: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Patient Signature (Guardian/Parent): \_\_\_\_\_ Date: \_\_\_\_\_