Client Information

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_

Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Gender: Male \_\_\_\_\_\_\_ Female \_\_\_\_\_\_

 (Month) (Day) (Year)

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_

Telephone Numbers: Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want us to notify your physician of this visit? Yes: \_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_

Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been living in South Florida? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled overseas before? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_

List countries to which you traveled before: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This Trip: Date of departure**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Location: Rural:** \_\_\_\_\_\_\_\_\_\_\_\_ **Urban:** \_\_\_\_\_\_\_\_\_\_\_ **Both:** \_\_\_\_\_\_\_\_\_\_\_\_

List countries of travel and length of stay in each.

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSONAL HISTORY**

**HAVE YOU EVER HAD: YES NO HAVE YOU EVER HAD: YES NO**

Altitude related illness \_\_\_\_ \_\_\_\_ Sleep apnea \_\_\_\_ \_\_\_\_

Pneumonia \_\_\_\_ \_\_\_\_ Typhoid fever \_\_\_\_ \_\_\_\_

Tuberculosis \_\_\_\_ \_\_\_\_ Cholera \_\_\_\_ \_\_\_\_

Pertussis \_\_\_\_ \_\_\_\_ Yellow fever \_\_\_\_ \_\_\_\_

Malaria \_\_\_\_ \_\_\_\_ Encephalitis \_\_\_\_ \_\_\_\_

Dengue fever \_\_\_\_ \_\_\_\_ Hepatitis \_\_\_\_ \_\_\_\_

Skin disease \_\_\_\_ \_\_\_\_ Gonorrhea \_\_\_\_ \_\_\_\_

Parasites \_\_\_\_ \_\_\_\_ Syphilis \_\_\_\_ \_\_\_\_

Recurrent diarrhea \_\_\_\_ \_\_\_\_ Chlamydia \_\_\_\_ \_\_\_\_

Shingles \_\_\_\_ \_\_\_\_ Herpes \_\_\_\_ \_\_\_\_

HIV/AIDS \_\_\_\_ \_\_\_\_ Rheumatic fever \_\_\_\_ \_\_\_\_

Cancer \_\_\_\_ \_\_\_\_ Heart disease \_\_\_\_ \_\_\_\_

Poisoning: □ Food □ Chemical □ Drug Poisoning

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a medical condition that is stable now, but that may recur while traveling? Yes\_\_ No \_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?

Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Have you had any operations? Yes\_\_\_\_\_ No\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any transfusions of blood or blood products recently? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Have you ever been hospitalized for any illness: Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES/SENSITIVITES**

**Are you allergic to Yes No Are you allergic to Yes No**

Eggs \_\_\_ \_\_\_ Yeast \_\_\_ \_\_\_

Dairy products \_\_\_ \_\_\_ Soy, wheat \_\_\_ \_\_\_

Gelatin \_\_\_ \_\_\_ Fish \_\_\_ \_\_\_

Penicillin \_\_\_ \_\_\_ Sulfites \_\_\_ \_\_\_

Latex \_\_\_ \_\_\_ Sulfa drugs \_\_\_ \_\_\_

Mycine \_\_\_ \_\_\_ Codeine \_\_\_ \_\_\_

Aspirin \_\_\_ \_\_\_ Other antibiotics \_\_\_ \_\_\_

Insect bites \_\_\_ \_\_\_ Adhesive tape \_\_\_ \_\_\_

Any medication (s) \_\_\_ \_\_\_

Name of medication (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other allergies? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medical Problems**

**Any trouble with:** Yes No Yes No

Eye disease/Impaired sight \_\_\_ \_\_\_ Ear disease/Impaired hearing \_\_\_ \_\_\_

Gastrointestinal trouble \_\_\_ \_\_\_ Ulcer \_\_\_ \_\_\_

Change in appetite/eating habits \_\_\_ \_\_\_ Indigestion \_\_\_ \_\_\_

Kidney/bladder disease \_\_\_ \_\_\_ Colitis \_\_\_ \_\_\_

Liver/gall bladder disease \_\_\_ \_\_\_ Constipation \_\_\_ \_\_\_

Kidney stones \_\_\_ \_\_\_ Diarrhea \_\_\_ \_\_\_

 Jaundice \_\_\_ \_\_\_ Infections \_\_\_ \_\_\_

 Gall stones \_\_\_ \_\_\_ Hepatitis \_\_\_ \_\_\_

Nose/sinuses \_\_\_ \_\_\_ Throat \_\_\_ \_\_\_ Fainting spells \_\_\_ \_\_\_ Seizures \_\_\_ \_\_\_

Convulsions \_\_\_ \_\_\_ Psoriasis \_\_\_ \_\_\_

Dizziness \_\_\_ \_\_\_ Headaches \_\_\_ \_\_\_

Blood pressure problems \_\_\_ \_\_\_ Palpitations \_\_\_ \_\_\_

Thyroid disease \_\_\_ \_\_\_ Vaginitis \_\_\_ \_\_\_

 Emotional problems \_\_\_ \_\_\_ Arthritis \_\_\_ \_\_\_

 Cough \_\_\_ \_\_\_ Swelling of: □ Hands □ Feet □ Ankles

 Shortness of breath \_\_\_ \_\_\_ Extreme: □ Tiredness □ Weakness

 Spitting up blood \_\_\_ \_\_\_ Heart problems \_\_\_\_ \_\_\_

 Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of lase menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take birth control pills or other hormones? Yes \_\_\_\_\_\_\_ No\_\_\_\_\_

Do you take any other medications regularly? Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_

What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates of Most Recent Vaccine**

**Vaccines: Date:**

Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mumps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rubella \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumococcus (pneumonia) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Polio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rabies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholera \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typhoid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Japanese Encephalitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HPV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Covid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yellow Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person completing questionnaire \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_