



Date: _____ How did you hear about **STATMed**? Billboard Newspaper Yellow Pages TV-Channel 7
Radio- OKOB-AM 98.5 Oldies 106.3 Talk FM
 Friend _____

Name: _____

Address: _____ City _____ State _____ Zip _____

Phone (Home) _____ Cell: _____ Work: _____ email: _____

Date of Birth ____/____/____ Age _____ Gender: Female Male Social Security #: _____ - _____ - _____

Occupation _____ Employer _____

Are You: Single Committed Relationship Married Divorced Widow

For your privacy, please indicate how we should contact you:
 Mail Home Phone Cell Phone Work Phone

MEDICAL INFORMATION

Date of last Medical Exam _____ Physician _____

Do you smoke? - No, never. No, but I used to. When did you quit? _____
 Yes How much? _____ When did you start? _____

Do you drink alcohol: No Daily Social Rare

Allergies: None Yes _____

Medical Problems _____

Current Medications _____

Surgeries and Dates _____

Injuries and Dates _____

Have you ever had a blood transfusion? No Yes When? _____

WOMEN -Have you been pregnant? No Yes How many times? _____ How many children did you have? _____
Miscarriage? _____ Abortion? _____ C-section? _____ Kid(s) Ages? _____

MEN - Do you have children? No Yes How many? _____ Ages? _____

Please indicate if ANYONE IN YOUR FAMILY has any of these problems:

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug Addiction What drug? _____ | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis Type _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pulmonary fibrosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Sjogren's Syndrome |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroid | |

Signature _____