

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 _____

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

Parent(s)/Guardian's Name: _____

Parent's Phone (Home) _____ Cell: _____ Work: _____

School _____ Grade _____

Who lives with you? _____

Does anyone smoke in the house? Yes No

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? _____

GIRLS -Have you been pregnant? No Yes How many times? _____ How many children did you have? _____
Miscarriage? _____ Abortion? _____ C-section? _____ Ages? _____

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

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

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

Signature _____