PERSONAL INFORMATION

Patient Name: ____ Date: _____________________

Reason for Visit: ____

Date of Birth: ____ / ____ / ________ Age: ______ Sex: M F Married Single Divorced

Social Security Number: ____________-__________Driver's License Number: ___________________

Street Address: ____

City: _______________________ State: _____________________ Zip: __________________

Home Phone: (____) ________________________ Cell Phone: (_____) _______________________

Email: _______________________________________

Employer: ___________________________________ Work Phone: (_____) _____________________

Occupation: __________________________________ FAX: (______) _________________________

Spouse: ____________________________________ Occupation: _____________________________

Emergency Contact: _________________________________ Phone: ______________________

Patient Referred By: ____

PAST MEDICAL HISTORY

Prior Surgeries: ____

Past Medical Illnesses: ____

Are you currently being treated forany medical condition (Yes/No) ____________________________

If yes, please list medical condition and current treatment: ______________________________

Family History of Illnesses: ____

Current Medications: ____

Medication Allergies: ____________________________ Easy Bruising or Bleeding: Yes / No ______

Personal Physician: __________________________________ Phone (_____) ___________________

Date of Last Physical Exam: ___________________________ By: __________________________

Ever Seen a Psychiatrist or Psychologist? _________________ When? __________________________

PATIENT HEALTH QUESTIONAIRE

Height: _________ Weight: __________ Recent weight gain or loss:____________________

Recent Chest X-Ray: (Y / N) ____ Comments: ____________________________________

Recent EKG: (Y / N) ____ Comments: ____________________________________

Recent Mammogram: (Y / N) ____ Comments: ____________________________________

Smoking History: (Y / N) ____ If yes, please give daily amount: _________________________

Drink Alcohol: (Y / N) ____ If yes, please give daily amount: _________________________

Have you ever had the history of the following?

Heart attack, stroke, rheumatic fever……. Y / N ____
High/low blood pressure………………… Y / N ____
History of chest pain…………………….. Y / N ____
Do your ankles swell…………………….. Y / N ____
Do you get short of breath easily……….. Y / N ____
Asthma…………………………………… Y / N ____
Hives, rashes or skin disorders………….. Y / N ____
Fainting spells or seizes………………….. Y / N ____
Diabetes………………………………….. Y / N ____
Hepatitis, jaundice, cirrhosis……………. Y / N ____
Stomach ulcers or heart burn……………. Y / N ____
Arthritis………………………………….. Y / N ____
Kidney problems………………………… Y / N ____
Tuberculosis or persistent cough……….. Y / N ____
Coughing up blood………………………. Y / N ____
Venereal disease…………………………. Y / N ____
Emotional disorders……………………… Y / N ____
Excessive bleeding with prior surgery…… Y / N ____
Blood disorders or anemia……………….. Y / N ____
Tumors of the mouth, nose or throat……… Y / N ____
HIV/ Aids…………………………………. Y / N ____

If yes to any of the above, please elaborate
____
____
____
____
____

Are you taking any of the following?

Antibiotics……………..…. Y / N ____
Blood thinners…………… Y / N ____
Diet Pills………………..… Y / N ____
Steroids, NSAIDS……..... Y / N ____
Aspirin, Motrin………….. Y / N ____
Insulin or Diabetic Meds… Y / N ____
Heart Medicine………….. Y / N ____
Herbal Supplements…….. Y / N ____
Birth Control Pills………. Y / N ____
Hormone Supplements….. Y / N ____

If Yes to any of the above, please give Name and Dose of medication:
____
____
____
____

Allergies and Sensitivities

Local Anesthetics………. Y / N ____
General Anesthetics……. Y / N ____
Antibiotics (Penicillin)…. Y / N ____
Barbiturates, Sedatives…. Y / N ____
Morphine or Codeine..…. Y / N ____
Adhesive Tapes………… Y / N ____
Latex…………………… Y / N ____

Signature of Patient, Parent or Guardian: ____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

Contact Number: (800) 633-2322

Website: www.mbc.ca.gov

PLEASE READ & SIGN THE FOLLOWING:

I, ____ understand that Dr. Matlock is

(Print your full name)

licensed and regulated by the Board.

SIGNATURE: ___________________________________ DATE: ___________________