Birmingham Integrative Health, P.C.
Patient Information

Patient's Full Name: _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____**Zip:**_____

Home #: _____ **Cell #:**_____

Work/Alt #: _____

Preferred Appointment Reminder Method: (Circle)

Home Phone Cell Phone Work/Alt Phone

If PATIENT is a MINOR

Parent's Name: _____

Parent's Phone Number: _____

Emergency Contact

Name: _____ **Relationship:** _____

Phone Number: _____

Pharmacy (Name, Phone Number)

Regular: _____

Compounding: _____

Mail In: _____

Insurance Information

Insurance Name: _____

Policy Holder's Name: _____ **Relationship:** _____

Date of Birth: _____ **Social Security** (billing purposes)**:** _____

Policy Holder's Phone Number: _____ **Effective Date:** _____

Group Number: _____ **Policy/Member Number:** _____

Copay: _____ **Deductible:** _____

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Personal Medical History: (Circle/Explain)

Acid Reflux
ADHD
Allergies, Seasonal
Anemia: _____
Anxiety
Arrhythmia: _____
Arthritis: _____
Asthma
Cancer: _____
Dementia
Depression
Diabetes: _____
GI Disease: _____
Headaches/Migraines
Heart Attack (MI)
Heart Disease: _____
High Blood Pressure
High Cholesterol
Kidney Disease: _____
Liver Disease
Lung Disease: _____
Osteopenia/Osteoporosis
Parkinson's
Seizure Disorder: _____
Sleep Apnea
Stroke
Thyroid Disease
Other: _____

Last Menstrual Period	**Date:**	**Normal Abnormal**
Colonoscopy	**Date:**	**Normal Abnormal**
Mammogram	**Date:**	**Normal Abnormal**
Bone Density	**Date:**	**Normal Abnormal**
Pap	**Date:**	**Normal Abnormal**

Family History

	Mother	Father	Grandparents	Siblings	Children
CAD					
Cancer: Type					
Dementia					
Diabetes: I, II					
High Blood Pressure					
High Cholesterol					
Stroke					
Thyroid Disease					

Surgical History Please Include Dates

_____
_____
_____
_____

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Social History

Marital Status: Married Single Divorced Widowed
Number of Children: _____
Smoker: No, never No, Quit _____ Yes, Type_____ Amount _____ Years_____
Alcohol: Never Quit_____ Rarely Weekly Daily
Recreational Drugs: _____
Sexually Active: Yes No
Occupation: _____

Please list medications, vitamins, herbs, supplements you are currently taking

Name	Strength	How often do you take it?

Are you allergic to any medications?

No Known Yes (please specify and include what type of reaction you had)

_____
_____

What is the reason for your visit today?

__ Get established with a primary care physician

__ Hormone imbalance
__ Thyroid Disorders
__ Weight Loss
__ Fatigue
__ Trouble Sleeping
__ Acupuncture, what problem? _____
__ Sick _____
__ Other _____

_____

_____