

Name _____ Today's Date _____

Date of Birth _____ Age _____ M or F **Height** _____ **Weight** _____

Home # _____ Work # _____ Cell# _____

Email _____ Address _____

City _____ State _____ Zip Code _____

What are you being seen for _____ (Right or Left)

Date of Onset _____ How did this occur? _____

Referred by: _____ Private Medical Doctor _____

Job/Occupation _____ Employer _____

Sports/ Exercise _____

Have you or anyone in your family seen Dr. Gavin before? _____

If so, Whom? _____

Medical Problems _____

Medications _____

Preferred Pharmacy _____ **City:** _____

Previous Surgery _____

Allergies _____

Smoke: yes or no

Alcohol: yes or no

Recreational Drugs: yes or no

Patient History:

___ Hiatal hernia

___ Seizures

___ Irregular Heart Beat

___ MI (heart attack)

___ Ulcer

___ Migraines

___ High Blood Pressure

___ PVD/DVT (blood clots)

___ Diabetes

___ Syncope

___ Angina/ Chest Pain

___ Irregular Hear Beat

___ Thyroid

___ Asthma/ Emphysema

___ Rheumatoid Disorders

___ MVP (heart murmur)

___ UTI

___ Bronchitis/Pneumonia

___ Congestive Heart Failure

___ Skin Disorders

Family History: _____
