

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: \_\_\_\_\_

\_\_\_\_\_