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: _____

_____