### MEDICAL HISTORY

**Do you have a history of (Check all that apply, if yes, please explain):**

- [ ] Alcohol or drug abuse:
- [ ] Anemia:
- [ ] Asthma or lung disease:
- [ ] Autoimmune disease (rheumatoid arthritis, lupus, etc.):
- [ ] Back or joint problems/arthritis:
- [ ] Blood clot in leg or lungs:
- [ ] Brain or nerve disorders/seizures:
- [ ] Cancer/Leukemia/Lymphoma:
- [ ] Chronic or recurrent skin disease:
- [ ] Diabetes Type 1 or 2:
- [ ] Ear, Nose, or Throat problems:
- [ ] Frequent severe headaches or migraines:
- [ ] Gynecological problems such as abnormal bleeding:
- [ ] Heart disease such as high cholesterol or high blood pressure:
- [ ] Hives or anaphylaxis:
- [ ] Infections (HIV, Lyme disease, MRSA, Tuberculosis/TB etc.):
- [ ] Kidney or bladder disease:
- [ ] Liver or gallbladder disease/hepatitis:
- [ ] Mental health disorder:
- [ ] Other blood disorders (i.e. sickle cell, thalassemia etc.):
- [ ] Stomach or intestinal problems:
- [ ] Stroke:
- [ ] Thyroid/endocrine disease:
- [ ] Vision or hearing problems (except glasses):
- [ ] None of the above

**Do you have allergies or reactions to medication, food, and/or environmental factors?**

- [ ] Yes, please specify:
- [ ] No

**Have you had any surgeries in the past?**

- [ ] Yes, please list surgeries and dates:
- [ ] No

### FAMILY HISTORY

**Family History (check all that apply and explain):**

- [ ] Heart disease such as high cholesterol or high blood pressure:
- [ ] Stroke:
- [ ] Blood Clot in leg or lungs:
- [ ] Anemia or other blood disorders:
- [ ] Back or joint problems/arthritis:
- [ ] Blood clot in leg or lungs:
- [ ] Cancer/Leukemia/Lymphoma:
- [ ] Infections (HIV, Lyme disease, MRSA, Tuberculosis/TB etc.):
- [ ] Diabetes Type 1 or 2:
- [ ] Mental health disorder:
- [ ] Alcohol or drug abuse:
- [ ] Other (please describe):
- [ ] None of the above

- [ ] I do not know the medical history of my family
DEMOGRAPHIC INFORMATION

Legal Name: ______________________________________ Preferred Name: ______________________________________

Last First MI

Preferred Pronoun: □ She, Her, Hers □ He, Him, His □ They, Them, Theirs □ Ze, Hir, Hirs □ Xe, Xem, Xyrs

□ Other (please specify): _____________________________

Preferred Language: □ English □ Chinese including Mandarin, Cantonese □ French □ German □ Italian

□ Japanese □ Korean □ Russian □ Spanish □ Tagalog □ Vietnamese □ Other (please specify): _____________________________

Red ID: ___________________________ Birthdate: ___________________________ Birth Sex: □ Male □ Female □ Intersex

Current Address: ____________________________________________________________________________________

Phone Number: ___________________________ Email address: ___________________________

INSURANCE INFORMATION (IF APPLICABLE)

Please note that we do not bill insurance.

Name of Insurance Carrier: __________________________________________________________________________

Policy Holder’s Name: ______________________________________________________________________________

Member’s Name: ____________________________________________________________________________________

Policy Number: _____________________________________________________________________________________

Group Number: _____________________________________________________________________________________

EMERGENCY CONTACT INFORMATION

Name: ___________________________ Phone Number: ___________________________

Relationship: _____________________________________________________________________________________

PLEASE READ AND SIGN

I affirm that I have filled out this form to the best of my knowledge. I understand that it is important to inform my healthcare provider if the information changes.

________________________________        ______________________        ______________________
(Signature of Patient)                                                     (Red ID)                                                     (Date)