310 W. Lea St. Suite B
CARLSBAD, NM 88220
PHONE: (575) 725-5936 FAX: (575) 725-5937

PATIENT PROFILE

PATIENT NAME:____

D.O.B: ____

ADDRESS: ____

MAILING ADDRESS:____

HOME PHONE: ____________________CELL:____________________

EMAIL:____

WORK PHONE:____

SOCIAL SECURITY:____________________

EMERGENCY CONTACT/NEXT OF KIN

EMERGENCY CONTACT: ____________________RELATIONSHIP:____________________

ADDRESS:____

HOME PHONE:____________WORK PHONE: ____________CELL:____________

EMERGENCY CONTACT: ____________________RELATIONSHIP:____________________

ADDRESS:____

HOME PHONE:____________WORK PHONE: ____________CELL:____________

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HEALTH HISTORY

What is the reason for today's visit? ____

SYMPTOMS: Place a check mark next to the symptoms that you currently have or have had within the last year

GENERAL

__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Nervousness
__ Numbness
__ Sweats

MUSCLE/JOINT/BONE

__ Arm/Head
__ Back
__ Legs/Feet
__ Neck
__ Shoulders

GENITOURINARY

__ Blood in urine
__ Frequent Urination
__ Bladder Control
__ Painful Urination

GASTROINTESTINAL

__ Poor appetite
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting
__ Vomiting blood

SKIN

__ Bruise easily
__ Hives
__ Itching
__ Change in moles
__ Rash
__ Scars
__ Non-healing wounds

EYE/EAR/NOSE/THROAT

__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache
__ Ear Discharge
__ Hay Fever
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Sinus Problems
__ Vision -- flashes
__ Vision -- halos

Any Other Health Complaint:

____

____

____

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__ Aids	__ Cancer	__ Heart Disease	__ Miscarriage	__ Scarlet Fever
__ Alcoholism	__ Cataracts	__ Hepatitis	__ Mononucleosis	__ Stroke
__ Anemia	__ Chicken Pox	__ Hernia	__ MS	__ Suicide Attempt
__ Anorexia	__ Diabetes	__ Herpes	__ Mumps	__ Thyroid Problem
__ Appendicitis	__ Drug Abuse	__ High Cholesterol	__ Pacemaker	__ TB
__ Arthritis	__ Emphysema	__ HIV	__ Pneumonia	__ Typhoid Fever
__ Asthma	__ Epilepsy	__ Kidney Disease	__ Polio	__ Ulcers
__ Bleeding Disorders	__ Glaucoma	__ Liver Disease	__ Prostate Problem	__ Vaginal Problems
__ Breast Lump	__ Goiter	__ Measles	__ Psych. Care	
__ Bronchitis	__ Gonorrhea	__ Migraines	__ Rheumatic Fever	
__ Bulimia	__ Gout			

Only if procedure requires this information ie. The O or P shot, female or male rejuvenation, or for acne treatments. If you have questions inquire with provider.

MEN ONLY

__ Breast Lump
__ Erection Difficulties
__ Lump in Testicles
__ Penis Discharge
__ Sore on Penis
__ Other

WOMEN ONLY

__ Abnormal Pap smear
__ Bleeding between periods
__ Breast Lump
__ Extreme Menstrual pain
__ Hot Flashes
__ Nipple discharge
__ Painful Intercourse
__ Vaginal discharge
__ other

Date of last period: ________________________

Date of last mammogram: __________________

Are you pregnant: _________________________

Number of children: _______________________

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HEALTH HABITS

Check what substance you use and how much:

Smoking Status: Never __ Current __ Former __ Socially__ **Level of use:** Heavy __ Light__

Cigarettes/Cigars __ Pipe __ Chew __ Electronic Cigarettes __ Other: ___________________________

Caffeine: __What kind? _______________________How often? ________________________________

Drugs: Never __ Current __ Former __ Socially__ **Substance:** ___________________________________

Alcohol: Never __ Current__ Former __ Socially__ **Level of Use:** Daily __ 3-4 x Week __ Socially Only__

Check if applicable: Stress __ Hazardous Substance _ Heavy Lifting __ Other: ______________________

Your Occupation: ____

***** *Please indicate type i.e. soda, tea, chew, cigarettes, etc.***

THIS SECTION MUST BE COMPLETED

Please include OTC medications, vitamins, and supplements

MEDICATION:	DOSE:	FREQUENCY:

Allergies:

MEDICATION	ALLERGY/REACTION

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I AUTHORIZE FUSION HEALTH AND WELLNESS TO RELEASE ANY OF MY MEDICAL INFORMATION FOR THE PURPOSE OF MEDICAL TREATMENT

(Including rx refills, making, or cancelling appts.)

Name: ____

Relationship to me: ____

Date of Birth: _______________________ Home Phone: ______________________

Name: ____

Relationship to me: ____

Date of Birth: _______________________ Home Phone: ______________________

Name: ____

Relationship to me: ____

Date of Birth: _______________________ Home Phone: ______________________

I want a restriction on the above medical information released. Please do not release any of my medical information regarding:

____

____

____

This authorization will be in effect until I notify Fusion Health & Wellness in writing that I want to terminate this authorization.

***Signature _______________________________________ Date: _______________**