Sole
WELLNESS & AESTHETICS

Welcome to our Practice

How did you hear about us?

□My doctor □ Friends,Family, Co-worker _____ □ Internet □Other_____

First Name _____ **Last Name** _____

Home # _____ **Cell #** _____

E-mail Address _____**DOB** _____

Gender: Male or Female

Race: □American Indian or Alaska Native □ Asian □ African American □ Caucasian □ Hispanic □Other

Ethnicity: □ Hispanic or Latino □Not Hispanic or Latino □No Answer **Spoken Language** _____

Address_____

Marital Status : □ Single □ Married □ Divorced □ Widowed

EMERGENCY CONTACT

NAME _____ Phone # _____ Relationship**:** _____

PHARMACY INFO (NAME, **INCLUDE ZIP**): _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID # _____ Group # _____

SECONDARY INSURANCE

Insurance Company Name: _____
ID # _____ Group # _____

PHONE: 732-305-0891
FAX: 732-510-5236

3221 RT 38, SUITE 102
MOUNT LAUREL, NJ 08054

REASON FOR TODAY'S VISIT Please include when the problem started, location, symptoms, what makes the pain decrease or increase? When does it occur? any previous treatment?

_____

_____

MEDICAL HISTORY: Please circle all that apply

High blood pressure	Headaches/Migraines	Anemia	Pneumonia
Kidney Diease	Dialysis	Tubercolosis	Drug/Alcohol Abuse
Heart Disease	Stroke	Chest Pain	Gout
Blood Clots	Tumor/Cancer	Seizures	Arthritis
Psychiatric	Anxiety	Asthma	Prostate Disorder
Diabetes Type I or Type II	Stomach disorder (GERD)	Thyroid Disease	_____

SURGICAL HISTORY

Surgery/Illness	Year	Physician

Primary Care Physician _____ **Phone**_____
Last Visit: _____

Endocrinologist (if diabetic) _____ **Last Visit**_____

FAMILY HISTORY Please circle and list RELATIONSHIP of FAMILY MEMBER

Diabetes	_____	Heart Disease	_____
Cancer	_____	Stroke	_____
Kidney Disease	_____	High Blood Pressure	_____
OTHER	_____	OTHER	_____

SOCIAL HISTORY

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation _____ **Shoe Size** _____

Number of Caffeine drinks per day _____

Amount of Alcohol consumed per week _____

C**urrent smoker:** YES or NO **If yes, how many packs/day**_____

How many years? _____

Previous smoker: YES or NO

If yes, how many packs/day?_____**How many years?**_____**Year Quit**_____

Are you pregnant? YES or NO **Are you breastfeeding?** YES or NO

MEDICATIONS: Please list all prescriptions and over-the-counter medications and the dosages:

ALLERGIES_____

HEIGHT _____ **WEIGHT**_____

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