



ENHANCED WELLNESS *of* NEW MEXICO

JOSEPH A. JAROS MD | JAN C. JAY, DOM

5200 Eubank NE, Suite C3, Albuquerque, NM 87111 | (505) 323-8100

PATIENT GENERAL INFORMATION

PERSONAL

Patient name: Date:

Date of birth: Age: Height: Weight: Gender: M F

Marital status (check one): Single Married Divorced Widow Cohabiting

Occupation: Retired

Home address:

City: State: Zip:

Home phone: Cell phone: Work phone:

e-Mail address: May we contact you via email? Yes No

Emergency contact name: Phone:

Referred by:

Have you had acupuncture before? Yes No Chinese herbal medicine? Yes No

Your reason for visiting today:

Is your problem getting worse? Yes No Does it bother you: Sleep Work Other:

Have you been given a diagnosis for this problem? Yes No If yes, what?

Any other complaints?

Are you under the care of a physician now? Yes No If yes, for what:

Current medications:

Current vitamins/supplements:

MAJOR HOSPITALIZATIONS:

Please indicate if you have been hospitalized for any serious medical illness or operation:

Date: Operation/Illness:

Date: Operation/Illness:

Date: Operation/Illness:

Date: Operation/Illness:

Please check here if you have had more than 4 such hospitalizations, then use the back of the form to complete your hospitalization list.

PERSONAL and FAMILY HISTORY

Please complete for yourself and each family member by checkmarking the appropriate boxes.

	SELF	FATHER	MOTHER	BROTHER	SISTERS	CHILDREN
Allergies						
Asthma / Bronchitis						
Anemia / Blood disorder						
Cancer or tumors						
Diabetes						
Epilepsy / Seizures						
High blood pressure						
Kidney / Bladder disorder						
Drug or alcohol addiction						
Tobacco addiction						
Arthritis						
Heart disease / Heart disorder						
Stroke						
Thyroid disorder						
Skin disorder						
Hepatitis						
Kidney disorder						
Tuberculosis						
Musculo-Skeletal disorder						
Headaches / Migraine						
AIDS / HIV						
Arteriosclerosis						
Birth trauma						
COPD / Emphysema						
Herpes						
Ulcers						
Pacemaker						
Other family history:						

Patient name (please print):

Patient or guardian signature: Date: