# OPTIMAL VITALITY

**201 S McPHERSON CHURCH RD**
**SUITE 231**
**FAYETTEVILLE, NC 28303**
**910-635-3035**

## Patient Information

Patient information as of today's date: _____
(Please print legibly and fill in all fields. If information is not available, please put N/A.)

**Personal Information**

Patient Name _____ SSN:_____ DOB _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Cell Phone (_____)_____ Home Phone (_____)_____

Work Phone (_____)_____ Email Address _____

Occupation _____ Employer _____

Preferred Language _____ Sex: __ Male __ Female

Emergency Contact Name/Phone Number _____ # (_____)_____

Reason for your visit today?

_____

Date of last physical _____ Name of Primary Physician _____

Is your general health good? __ Yes __ No

Allergies? __ Yes __ No Known Drug Allergies
If yes, please list: _____

List all medications you are taking (prescription and OTC):

_____

_____

Do you take Aspirin, Advil, Motrin, Ibuprofen or anti-inflammatory medication more than once per week?
__ Yes __ No If yes, please explain: _____
Do you smoke? __ Yes __ No If yes, how many per day/for how many years: _____
Do you drink alcohol? __ Yes __ No If yes, how much/how often: _____
Do regularly use a tanning bed or sun exposure? __ Yes __ No If yes, how much/how often: _____
Do regularly take vitamins? __ Yes __ No If yes, what kind and how often: _____
Are you currently pregnant? __ Yes __ No Are you currently breastfeeding? __ Yes __ No
Are you currently trying to become pregnant? __ Yes __ No

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**Present/Past Medical History**

Have you ever had any of the following (please check all that apply):

__ Asthma
__ Autoimmune disorder
__ Chronic diarrhea
__ Diabetes
__ Excessive scarring
__ Heart valve disease
__ High/ low blood pressure
__ Irregular heart beat
__ Kidney disease
__ Multiple Sclerosis
__ Migraines
__ Seizures
__ Unusual mole
__ Thyroid disorder
__ Arthritis
__ Blood disorder
__ Clotting disorder
__ Depression
__ Excessive bleeding
__ Heart valve replacement
__ Hepatitis
__ Intestinal problems
__ Liver disease
__ Muscular Dystrophy
__ Rheumatic fever
__ Stomach problems
__ Tattoo/ permanent makeup
__ Anemia
__ Chest Pain
__ Colon problems
__ Easily Bruise
__ Heart Attack
__ Heart Failure
__ HIV
__ Keloids
__ Lung disease
__ MVP
__ Shortness of breath
__ Varicose veins
__ Stroke

__ Cancer: Please list type: _____

__ Other medical conditions: _____

Please list any cosmetic procedures you have had (surgical and non-surgical) with dates:

_____Date_____
_____Date_____
_____Date_____
_____Date_____

To the best of my knowledge, the information provided above is true and accurate. I agree to tell the staff of any changes to my health history or medications as they arise. I understand that information is necessary for your practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

_____ _____
**Printed Patient Name** **Date** **Signature of Patient**

_____ _____
**Practice Representative Name** **Signature of Practice Representative**