Defiance Chiropractic Center

Patient Vitals and Smoking Status Update

Patient Name:_____ **Date:**_____

Vitals:

Height:_____ Weight:_____ Blood Pressure:_____

Smoking Status:

___Current Every Day Smoker ___ Current Some Day Smoker ___Former Smoker ___Never Smoker

If you are over the age of 65, Have you had the pneumonia vaccination: Yes___ No___

If you are over the age of 40 & Female, Have you had a mammogram in the past year? Yes___ No___

Please list any drug allergies:

___None ___Sulfa ___Penicillin ___Morphine ___Codeine Others:_____

_____

Please list any medicines you are taking, along with dosages. (If you have a list of meds we will be happy to copy it for you)

Name Dose(example: 10mg) Frequency (example: 2 tablets per day)

PLEASE TURN OVER AND FILL OUT REVERSE SIDE

PATIENT INFORMATION UPDATE

Address_____

Home Phone_____ Work Phone_____

Cell Phone_____ Birthdate_____ S.S.#_____

Would you like to receive appointment reminders by _____ email_____text message?

If interested in an email notice, what is your email address? _____

If you would like to receive text reminders, who is your cellular carrier?_____

Employer_____ Spouse_____

Spouse's Birthdate:_____ Spouse's S.S.#_____

A previous name your file may be found under_____

What is your preferred language?_____

What is your race: _____Asian_____Black_____Caucasian_____Hispanic_____Native American_____Other