J. Michael Herr, DO, LLC
Initial Patient Medical Registration

Patient Name _____________________ Date of Birth - ___ / ___ / ____ Today's Date - ___ / ___ / ___

What is/are your main complaint(s) or symptom(s) today? ___________________________________
____

Please list all medications or supplements you take (Rx or non-Rx): ___________________________
____

Please list all allergies that you have - medications, food and environmental: ____________________
____

Please list all surgeries that you have had and the year they occurred: __________________________
____

Please list serious illnesses in your primary relatives (parents, grandparents, siblings): ______________
____

Current work: ________________________________ ; smoking history: _______________________
Alcohol use: ________________________ ; exercise routine: _________________________________

Please provide a brief account of any of the following illnesses, if present: cancer, diabetes, seizure disorder, heart disease, hypertension, stroke/TIA, thyroid disease, anemia, asthma, infectious disease.
____
____

Please list any other long-term or chronic medical problems or diagnoses you have:
____

Please list a brief account of any history of depression, anxiety or other significant psychiatric condition.
____
____

Any other medical/social information that you want to bring attention to the doctor? ______________
____

Reviewed by _________________________ , ___ / ___ / _____