DAVID L. WALTERS, D.O. Patient Name:_____

Health History

Date of Last: Physical Exam _____ X-rays _____Type_____
MRI, CT-Scan, Bone Scan _____ Blood Test _____
Injuries / Surgeries you have had:_____
._____

Place checkmark on the line to indicate if you, or a family member have, or have had, any of the following:
(Y = You, M = Mother, F = Father)

	Y	M	F		Y	M	F		Y	M	F
AIDS/HIV…….....				Heart Attack……				Prostate Problems……..			
Alcoholism……				Heart Disease……..				Rheumatic Fever…….			
Allergies……				Hepatitis……..….				Rheumatoid Arthritis……			
Alzheimer's ……..				Hernia……				Scarlet Fever……			
Anemia……..				Herpes……..				Stroke…….			
Arthritis……..				High Blood Pressure…..				Thyroid Problems…….			
Asthma……..				High Cholesterol…….				Tumors / Growths……			
Bleeding Disorders……..				Kidney Disease……				Tuberculosis…….			
Breast Lumps……...				Liver Disease……				Ulcers……			
Bronchitis……..				Lupus……				Vaginal Infections……			
Cancer……..				Lyme's Disease……				West Niles Disease…….			
Chemical Dependency...				Migraines……..				Other……..			
Colon Disorders……...				Monocucleosis……..				……			
Diabetes……				Multiple Sclerosis……				……			
Emphysema……				Osteoporosis…….				……			
Epilepsy……				Pacemaker……				……			
Fibromyalgia……				Parkinson's Disease……				……			
Glaucoma……				Pneumonia……				……			
Gout……...				Polio……...				……			

KNOWN DRUG ALLERGIES

._____
._____
._____
._____

DAILY HEALTH FACTORS

___Smoking / Packs per day_____
___Alcohol / Drinks per day_____
___Caffeine Drinks / Per day_____
___High Stress Level / Reason_____

WORK ACTIVITY

___Sitting
___Standing
___Light Labor
___Heavy Labor

EXERCISE

___Daily ___Weekly
___Moderate
___Heavy
___None

CURRENT MEDICATIONS / SUPPLEMENTS

Medications / Supplements _____
._____
._____
Pharmacy Name / Location _____ Phone No. _____

AUTHORIZATION FOR TREATMENT / HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

I consent to and authorize the rendering of care by David L. Walters, D.O. and his medical staff, for myself / my minor child / the patient I am authorized to consent for, including treatment and performance of diagnostic procedures, including recommendation for out of office testing, including but not limited to medical, diagnostic, or non-invasive procedures. I understand that I / my minor child / the patient I am authorized to consent for, am/is under the care and supervision of David L. Walters, D.O. and it is the responsibility of the staff to carry out the instructions of Dr. Walters. I certify that no guarantee or assurance has been given as to results that may be obtained with treatment/care.

I have been given the opportunity to review the Notice of Privacy Practices and understand that I may give specific written instructions as to how my medical information may be released.

Patient's Signature_____ Date_____

Guardian's Signature_____ Date_____