VITA SANA
MEDICAL CENTER

Dr. Luca Lioce, N.M.D. Vita Sana Medical Center
4300 N. Miller Rd. Suite 144 Scottsdale, AZ 85251 (480) 579-5290

PATIENT INFORMATION

Last Name:_____ First Name:_____ Initial:____

Address: _____ Home Phone:_____ Cell:_____

City:_____ State:____ Zip:_____ Sex: M F

Status (Circle One): Minor / Single / Married / Long Term Partner / Widowed

Employer: _____ Occupation: _____

Work Phone: _____ Date of Birth: _____

Email: _____

Emergency Contact:

Name: _____ Relation: _____ Phone #_____

When was your last physical exam? _____/_____/_____ Physician's Name: _____

1)Are you currently under medical treatment? **Y / N**
If yes, please describe _____
2)Have you had any serious illnesses or operations? **Y / N**
If yes, please describe_____
3)Are you currently taking any medications? **Y / N**
If yes, please describe _____
4)Do you smoke? **Y / N**
If yes, how much? _____
5)Do you use alcohol? **Y / N**
If yes, how much? _____
6)Do you use any other drugs not prescribed by a physician? **Y / N**
If yes, please describe _____

7)Have you had any allergic reactions to the following?

Local Anesthetics (eg. Novocain)	**Y**	**N**
Penicillin or other antibiotics	**Y**	**N**
Sulfa Drugs	**Y**	**N**
Barbiturates (sleeping pills)	**Y**	**N**
Sedatives	**Y**	**N**
Iodine	**Y**	**N**
Aspirin	**Y**	**N**
Other	**Y**	**N**

If yes, what happens?
_____

DATE: ___ / ___/20___

Have you ever had the following?

Anemia	Y	N	Heart Disease	Y	N	Pneumonia	Y	N
Anorexia (no appetite)	Y	N	Heart Disease	Y	N	Polio	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Prostate Problems	Y	N
Asthma	Y	N	Hepatitis – Type ____	Y	N	Psychiatric Care	Y	N
Back Problems	Y	N	Hernia	Y	N	Respiratory disease	Y	N
Bleeding Tendency	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Blood Disease	Y	N	High Blood Pressure	Y	N	Scarlet Fever	Y	N
Cancer	Y	N	HIV/AIDS	Y	N	Shortness of Breath	Y	N
Chemotherapy	Y	N	Jaundice	Y	N	Sinus Trouble	Y	N
Chicken Pox	Y	N	Kidney Disease	Y	N	Skin Rash	Y	N
Chronic Fatigue Syndrome	Y	N	Latex Sensitivity	Y	N	Stroke	Y	N
Circulatory Problems	Y	N	Liver Disease	Y	N	Thyroid Problems	Y	N
Congenital Heart Lesions	Y	N	Low Blood Pressure	Y	N	Tonsillitis	Y	N
Cough – persistent or bloody	Y	N	Measles	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Migraine Headaches	Y	N	Ulcer	Y	N
Drug addiction	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N
Emphysema	Y	N	Multiple Sclerosis	Y	N	Any Other Condition	Y	N
Epilepsy	Y	N	Mumps	Y	N	Please describe:_____		
Glaucoma	Y	N	Pacemaker	Y	N			

Diet *(please list a typical day's diet)*

Breakfast:
Lunch:
Dinner:
Snack:

Coffee/ Tea / Soda? Y / N _____ How many/day? _____

Water intake: _____ glass(es) / day

Exercise: Y / N What do you do? _____

How often /how long do you exercise?_____

I certify that the above information is complete to the best of my knowledge and have not knowingly omitted any significant condition/conditions that may be potentially life threatening.

Signature: _____ **Date:** _____