

PATIENT INFORMATION SHEET

SSN# _____

Appointment Date _____

Name _____ Marital Status: S M W D Other
Last First

Address _____
No. Street City, State Zip Code

Home Telephone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Age _____ Date of Birth ____/____/____ Spouse's Name: _____

Employer _____ Occupation _____

Health Insurance Co. _____ Source of Referral: _____

Emergency Contact Name: _____ Phone number: _____

Relationship _____

Name: _____ Date: _____

PATIENT'S HISTORY AND HEALTH QUESTIONNAIRE

Please complete the following as accurately as possible. The doctor will go over the answers with you.

FAMILY HISTORY:

<p>Father: Condition of health _____ cause of death: _____</p> <p>Mother: Condition of health _____ cause of death: _____</p> <p>Number of brothers: Living ____ Deceased ____ Cause of death: _____</p> <p>Number of sisters: Living ____ Deceased ____ Cause of death: _____</p> <p>Number of children: Boys: _____ ages: _____ Girls: _____ ages: _____ All healthy: _____ Any deceased? _____</p>	<p>Have any members of your family ever had the following? If so, please circle below.</p> <p>Diabetes Tuberculosis Headaches Epilepsy Cancer High Blood Pressure Stroke Allergy Stomach problems Nervous trouble Blood disease Goiter Arthritis Obesity Kidney disease Liver disease Thyroid disease Alcohol/drug abuse Other</p>
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PATIENT HISTORY:

ALLERGIES: Please list any Allergies or severe reaction to medicines, food, plants, chemicals, etc.:

MEDICATIONS: Are you taking any medications (prescription or non-prescription), vitamins, supplements, herbs, sleeping pills, or aspirins? If so, please give name of drug, amount taken, how often and how long you have been taking it.

_____	_____
_____	_____
_____	_____
_____	_____

Gynecologic History (women only):

Date last period: _____ Now occurs about every _____ days
 Duration: _____ Any abnormalities found? _____
 Flow: _____ Painful? _____
 Hot flashes? _____ Irregular? _____
 Number of pregnancies: _____ Spotting between periods? _____
 Breast trouble? _____ Do you perform monthly breast exams? _____
 Date of last gynecologic exam _____

PATIENT MEDICAL HISTORY (PLEASE CIRCLE):

<u>Respiratory</u>	<u>Genito/Urinary</u>	<u>General</u>
Sinus trouble	Bladder trouble	Skin
Allergies/Hay fever	Kidney trouble	Anemia
Asthma	Kidney stones	Serious injuries
Shortness of breath	Sexually transmitted disease	Surgeries
Bronchitis	Urinary tract infection	Back pain
Tuberculosis	Frequent urination	Measles
Pneumonia	Pain or burning with urination	Mumps
Emphysema		Chicken pox
Frequent colds		Cancer or Tumors
	<u>Gastro/Intestinal</u>	Arthritis
<u>Head/Neck</u>	Abdominal pain	Sleep problems
Headaches/Migraines	Gerd	Polio
Cataracts	Irritable bowel syndrome	Diabetes
Tonsillitis	Ulcer	Hypoglycemia
Fits or convulsions	Gall stones	High cholesterol
Paralysis	Liver trouble	Gout
Fainting	Jaundice	Edema
Unconsciousness	Hepatitis	Leg cramps
Goiter	Constipation	Mononucleosis
Thyroid disease	Parasites	Alcoholism/Drug addiction
Dizziness	Constipation	Anorexia
	Diarrhea	Bulimia
<u>Cardiac/Circulatory</u>	Colitis	Other
Rheumatic fever	Hemorrhoids	
Heart trouble	Hiatus hernia	
Palpitations		
High or low blood pressure		
Chest pains		
Phlebitis		
Varicose veins		

When was your last physical exam? _____ Any abnormalities found? _____
 Date of last dental visit: _____ Date of last chest x-ray: _____
 Date of last tetanus injection: _____ Date of last electrocardiogram: _____
 Are you under any medical treatment now? _____

Do you presently smoke cigarettes? Y N How many packs a day? _____
 If not presently but in the past, indicate no. of years & no. of packs per day:
