PATIENT INFORMATION SHEET

Please bring all medication bottles with you to your appointment

Patient Name: ______________________________ DOB: ____________ Date Completed: ____________

Allergies: ____

Do you have or have you been treated for any of the following:

Arthritis	☐Yes	☐No	Irregular Heart Beat	☐Yes	☐No	Acid reflux	☐Yes	☐No
Asthma	☐Yes	☐No	Heart attack *Year:*_____	☐Yes	☐No	Ulcers	☐Yes	☐No
COPD/Emphysema	☐Yes	☐No				Hepatitis	☐Yes	☐No
Sleep Apnea	☐Yes	☐No	Stroke	☐Yes	☐No	Seizures	☐Yes	☐No
Diabetes	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Mental Health	☐Yes	☐No
Thyroid	☐Yes	☐No	Blood clots	☐Yes	☐No	Teeth/Gum Disease	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Bleeding disorder	☐Yes	☐No			

Other Medical Conditions: ____

Surgical History (list all prior surgeries and approximate dates): ____

____

How many visits to the Emergency Room (ER) have you had in the past 12 months?

☐ 0 ☐ 1-2 ☐ 3+

How many overnight stays at the hospital have you had in the past 12 months?

☐ 0 ☐ 1-2 ☐ 3+

Last Menstrual Period	Date:	Provider:
Pap Smear	Date:	Provider:
Colonoscopy	Year:	Provider:
Mammogram	Date:	Provider:
Dexa/Bone Density	Date:	Provider:
Last Flu Vaccine	Date:	
Pneumonia Vaccine (Pneumovax 23 or Prevnar 13)	Date:	
Tdap/Tetanus/Pertussis Vaccines	Date:	

SOCIAL/CULTURAL HISTORY

What is the highest level of school you have finished?

☐ Education Level: Less than high school ☐ Some college, no degree
☐ High school degree or equivalent ☐ College degree or beyond

Do you live alone? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No ☐ Patient declined to answer
Do you use recreational drugs? ☐ Yes ☐ No ☐ Patient declined to answer

Do you use tobacco products and are you interested in quitting?

☐ Yes ☐ No ☐ Patient declined to answer

FAMILY HISTORY

Father: Living: ☐ Deceased: ☐ **Mother:** Living: ☐ Deceased: ☐

Siblings: Living: ☐ Deceased: ☐ **Children:** Living: ☐ Deceased: ☐

Alcoholism:	☐ Father	☐ Mother	☐ Siblings	Heart Disease:	☐ Father	☐ Mother	☐ Siblings
Anemia:	☐ Father	☐ Mother	☐ Siblings	High Cholesterol:	☐ Father	☐ Mother	☐ Siblings
Asthma:	☐ Father	☐ Mother	☐ Siblings	Kidney Disease:	☐ Father	☐ Mother	☐ Siblings
Arthritis:	☐ Father	☐ Mother	☐ Siblings	Migraines:	☐ Father	☐ Mother	☐ Siblings
Mental Health:	☐ Father	☐ Mother	☐ Siblings	Osteoporosis:	☐ Father	☐ Mother	☐ Siblings
Cancer:	☐ Father: ____________________	☐ Mother: ____________________	☐ Siblings: ___________________				
COPD/Emphysema:	☐ Father	☐ Mother	☐ Siblings	High Blood Pressure:	☐ Father	☐ Mother	☐ Siblings
Dementia:	☐ Father	☐ Mother	☐ Siblings	Stroke:	☐ Father	☐ Mother	☐ Siblings
Diabetes:	☐ Father	☐ Mother	☐ Siblings	Thyroid Disease:	☐ Father	☐ Mother	☐ Siblings
DVT (Blood Clot):	☐ Father	☐ Mother	☐ Siblings				

REVIEW OF SYMPTOMS

Are you currently having any of the following?

Blood/Lymph

Bruising/Clotting ☐Yes ☐No
Easy bleeding ☐Yes ☐No

Cardiovascular

Chest pain ☐Yes ☐No
Palpitations ☐Yes ☐No

Head/Eyes

Visual changes ☐Yes ☐No
Light sensitivity ☐Yes ☐No
Blurred vision ☐Yes ☐No
Double vision ☐Yes ☐No
Headaches ☐Yes ☐No

Respiratory

Cough ☐Yes ☐No
Wheezing ☐Yes ☐No
Coughing blood ☐Yes ☐No
Snoring ☐Yes ☐No

Skin

Bruising ☐Yes ☐No
Rashes ☐Yes ☐No
Skin lesions ☐Yes ☐No
Abnormalities ☐Yes ☐No

Gastrointestinal

Stomach pain ☐Yes ☐No
Weight gain ☐Yes ☐No
Weight loss ☐Yes ☐No
Nausea ☐Yes ☐No
Vomiting ☐Yes ☐No
Diarrhea ☐Yes ☐No
Trouble swallowing ☐Yes ☐No

Musculoskeletal

Hand/foot swelling ☐Yes ☐No
Back/neck problems ☐Yes ☐No

Ears/Nose/Throat

Easy bleeding ☐Yes ☐No
Face or neck lumps ☐Yes ☐No
Nose bleeds ☐Yes ☐No

Neurological

Muscle weakness ☐Yes ☐No
Numbness/tingling ☐Yes ☐No
Dizziness/instability ☐Yes ☐No
Lightheadedness ☐Yes ☐No

Endocrine

Heat or cold intolerance ☐Yes ☐No

Other medical problems not listed above:____