Date: _____

Patient Information Sheet

Last Name	First Name	Middle Initial	
Home Phone	Work Phone	Cell Phone	
E-mail Address	Date of Birth	Marital Status	Age

ADVANCED DIRECTIVES

Do you have: ☐ Durable Power of Attorney ☐ Living Will ☐ DNR(Do not Resuscitate) ☐ None of these

Please let us know if you would like more information on any of the above items.

MEDICATIONS & VITAMINS

Please list all of your medications, prescription and nonprescription, and the dosage amount:

Medications	**Dosage, how taken**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please list all vitamins, supplements and other over the counter products.

Vitamins/OTC	**Dosage, how taken**
1.	
2.	
3.	
4.	

Please list medication <u>ALLERGIES</u> or medications you cannot take. Check here if <u>NO</u> allergies. ☐

1.	3.
2.	4.

PHARMACY INFORMATION

Preferred Pharmacy Name	Pharmacy Phone Number	Pharmacy Address
Alternative Pharmacy Name	Pharmacy Phone Number	Pharmacy Address

Name: _____

PAST MEDICAL HISTORY

Chief Complaint / Reason for Visit _____

Chronic Medical Problems _____

_____

Please place a check mark in the box if you have ever experienced any of the following conditions Also, if you know the year, please include it.

	Year		Year		Year		Year
☐ Allergies		☐ Blood Clots		☐ Gallbladder Disease		☐ MI/Heart Attack	
☐ Anemia		☐ Cancer		☐ Reflux/GERD		☐ Osteoarthritis	
☐ Angina		☐ CVA/Stroke		☐ Hepatitis C		☐ Osteoporosis	
☐ Anxiety		☐ COPD/Lung		☐ High Cholesterol		☐ Peptic Ulcer	
☐ Arthritis		☐ Coronary Artery		☐ High Blood Pressure		☐ Kidney/Renal	
☐ Asthma		☐ Crohn's Disease		☐ Irritable Bowels		☐ Seizures	
☐ Atrial Fibrillation		☐ Depression		☐ Liver Disease		☐ Thyroid Disease	
☐ Benign Prostatic Hypertrophy		☐ Diabetes		☐ Migraine Headaches		☐ Other	

PAST SURGICAL HISTORY

Please place a check mark in the box if you have ever had any of the following surgeries. Also, if you know the year, please include it.

	Year		Year		Year
☐ Angioplasty		☐ Colectomy (Colon		☐ Pacemaker	
☐ Angioplasty with Stent		☐ Colostomy (Wear a		☐ Small Bowel	
☐ Appendectomy		☐ Gastric Bypass		☐ Thyroidectomy	
☐ Arthroscopic Knee Surgery		☐ Hernia Repair		☐ Tonsillectomy	
☐ Back Surgery		☐ Hip Replacement		☐ Prostate Biopsy	
☐ CABG/Bypass Surgery		☐ Knee Replacement		☐ TURP / Prostate Removal	
☐ Carpal Tunnel		☐ Lasik		☐ Vasectomy	
☐ Cataract		☐ Liver Biopsy		☐ Other	
☐ Cholecystectomy (Gallbladder)		☐ ORIF/ Hip Fracture			

PAST DIAGNOSTICS

Please place a check mark in the box if you have ever had any of the following tests or procedures. Please include the last year this procedure was completed and the results, if known.

	Approximate Date	Results (if known)		Approximate Date	Results (if known)
☐ Colonoscopy			☐ Sigmoidoscopy		
☐ PPD			☐ Bone Density/ Dexa Scan		
☐ Lipid Panel			☐ Hepatitis C test		

FAMILY HISTORY

Please check if any family member has had any of the following conditions. Include information even if the person is deceased.
Please check here if you are adopted.☐

	Mother	Father	Sister	Brother	Grandparents	Other
Cancer: Type						
Cancer: Type						
Irritable Bowel Disease						
Polyps						
Ulcerative Colitis / Crohn's Disease						
Other:						

Name: _____

SOCIAL HISTORY & HEALTH MAINTENANCE

Do you use tobacco? ☐ No ☐ Yes ☐ Former Type of tobacco used? _____

If cigarettes, # of packs per day? _____ Years smoked? _____ Date Quit? _____

Other tobacco (cans, cigars) per day? _____ Years smoked? _____ Date Quit? _____

Do you drink alcohol? ☐ Currently ☐ Never ☐ Former Date Quit? _____

Type of alcohol? _____ Daily amount? _____ How often? _____

Employer: _____ **Occupation:** _____ **Year Retired** _____

Vaccine:	Date of last:	Vaccine:	Date of last:
☐ Hepatitis A	1st:_____ / 2nd: _____	☐ Hepatitis B (3 shot series)	1st:_____ / 2nd: _____ / 3rd: _____

Please check the box if you are <u>currently</u> experiencing any of the following:

General
- ☐ Chills
- ☐ Fatigue/Tiredness
- ☐ Fever
- ☐ Feel Lousy/Malaise
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes, Ears, Nose & Throat
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat
- ☐ Visual Changes

Respiratory/Lung
- ☐ Chronic Cough
- ☐ Cough
- ☐ TB Exposure
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular/Heart
- ☐ Chest Pain
- ☐ Calf Pain with Walking/Claudication
- ☐ Swelling, Fluid Retention/Edema
- ☐ Heart Racing/Palpitations

Gastrointestinal/GI
- ☐ Abdominal Pain
- ☐ Blood in Stools
- ☐ Change in Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

Urinary
- ☐ Dribbling
- ☐ Dysuria/Pain on Urination
- ☐ Hematuria /Blood in Urine
- ☐ Polyuria/Excessive Urination
- ☐ Slow Stream
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Retention

Circulation
- ☐ Blood Clots/Thrombophlebitis
- ☐ Ulcer of the Feet or Legs

Metabolic/Endocrine
- ☐ Brittle Hair
- ☐ Brittle Nails
- ☐ Cold Intolerance
- ☐ Hair Changes
- ☐ Heat Intolerance
- ☐ Hirsutism/Excessive Facial Hair
- ☐ Polydipsia/Excessive Thirst
- ☐ Polyphagia/ Excessive Eating

Neurological
- ☐ Dizziness
- ☐ Extremity Numbness
- ☐ Extremity Weakness
- ☐ Gait Disturbance/Difficulty Walking
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors

Mood
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Skin
- ☐ Contact Allergy
- ☐ Hives
- ☐ Itching
- ☐ Mole Changes
- ☐ Rash
- ☐ Skin Lesion

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Neck Pain

Hematologic/Blood
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymphadenopathy/ Enlarged Lymph Nodes

Allergies
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Other
- ☐ _____
- ☐ _____

_____ _____

Patient/Parent/Care Giver Signature Date