PATIENT INFORMATION SHEET

NAME:______________________ DOB:__________ DATE:________

ALLERGIES:____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____________

Alcohol: Currently Past Never Drinks/day:_____________

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder problems/Incontinence
Bleeding problems
Cancer:____________
Carpal Tunnel
Headaches
Crohn's Disease

COPD
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
Eczema
Emphysema
Gallstones
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure

High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Kidney Stones
Kidney Disease
Lupus
Liver Disease
Macular Degeneration
Migraines
Nosebleeds
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease

Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Sciatica
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period	Yes/No Date:____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dxa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

____

____

Surgical History: Please list all prior surgeries and approximate dates performed.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

FAMILY HISTORY:

FATHER: Living: Age________ Deceased: Age________

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:____

MOTHER: Living: Age________ Deceased: Age:________

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:____

Siblings:____

____

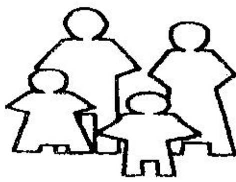
List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

____

____

Patient signature:______________________ Date:__________________

Provider reviewed:______________________ Date:__________________



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Please list all family/friend members whom you would like information released to:

Name:____________________ Relation:____________________

Name:____________________ Relation:____________________

Name:____________________ Relation:____________________

Name:____________________ Relation:____________________

Name:____________________ Relation:____________________

Do you have any of the following?:

1) Do Not Resuscitate form filled out? Yes:____ No:____

2) Living Will (End of Life Care)? Yes:____ No:____

3) Power of Attorney? Yes:____ No:____

If yes, please provide the office with a copy.

If no, please notify the office if you would like paperwork pertaining to any of the above.

____________________ Signature

____________________ Date