Date:_____

PATIENT INFORMATION FORM

The following will be kept in strictest confidence

Last Name First Middle	Birthdate:	Age:
Street Address	Gender M F	Birthplace
City State Zip	Home Phone	Work Phone
Employer Occupation	Marital Status S M W D Sep	
Social Security #	Emergency Contact (Name)	
Referred By:	Emergency Contact (Phone)	

Personal History

Do you have or have you ever had any of the following conditions:

YES	NO	CONDITION	YES	NO	CONDITION
☐	☐	AIDS / HIV	☐	☐	Heart Murmur
☐	☐	Alcohol / Drug Problems	☐	☐	Hemorrhoids
☐	☐	Anemia / Low Blood Count	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	Hernia
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Blood Clots	☐	☐	High Cholesterol
☐	☐	Cancer (Type:_____)	☐	☐	Infertility (Difficulty Getting Pregnant)
☐	☐	Cataracts	☐	☐	Kidney / Bladder Problems
☐	☐	Circulation Problems	☐	☐	Liver Disease / Jaundice / Hepatitis
☐	☐	COPD / Emphysema	☐	☐	Mental Trouble / Depression / Anxiety
☐	☐	Diabetes (Sugar)	☐	☐	Pneumonia
☐	☐	Easy Bleeding	☐	☐	Rheumatic Fever
☐	☐	Eating Disoder (Anorexia / Bulimia)	☐	☐	Seizures / Fits / Epilepsy
☐	☐	Eczema	☐	☐	Serious Injury / Serious Accident
☐	☐	Genital Herpes	☐	☐	Sickle Cell Anemia
☐	☐	Genital Infections (Chlamydia / Gonorrhea)	☐	☐	Skin Disorder
☐	☐	Genital Warts / HPV	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid Problem
☐	☐	Gout	☐	☐	Transfusion (Year:_____)
☐	☐	Hay Fever / Pollen Allergy	☐	☐	Tuberculosis (TB)
☐	☐	Headaches	☐	☐	Ulcers
☐	☐	Hearing Loss	☐	☐	Other (specify:_____)
☐	☐	Heart Attack / Heart Disease	☐	☐	Other (specify:_____)

Surgery / Hospitalization / Accident / Injury History

Please list any Surgeries / Hospitalization / Accidents / Injuries and the year

Operation / Condition Requiring Hositalization / Accident / Injury	Year

Personal Habits

Do you regularly drink alcohol?	Yes	No	If yes, what amount?_____
Do you drink > 4 cups of caffeinated beverages per day?	Yes	No	If yes, what amount?_____
Do you smoke?	Yes	No	If yes, how many packs per day?_____
			If yes, how many years?_____
Are you a former smoker?	Yes	No	If yes, how many packs per day?_____
			If yes, how many years?_____
Have you ever used street drugs?	Yes	No	If yes, what type?_____
Are you currently using street drugs?	Yes	No	If yes, what type?_____

Family History

Relative	Age	If, Decease, Age at Death	Medical Problem / Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibilings			
Spouse			
Children			

Medications

Please list the medications, with dosage and frequencies, that you currently use.

Please include over-the-counter and herbal medications

Medications	Dosage	Frequency

Allergies

Please list any drug allergies and the type of reaction you experience with each drug.

Drug	Reaction

Review of Symptoms

Please check any of the following symptoms that apply to you

Past	Present	Symptom	Past	Present	Symptom
☐	☐	Weight Changes (unexpected)	☐	☐	Trouble Swallowing
☐	☐	Fever	☐	☐	Heartburn
☐	☐	Chills	☐	☐	Constipation
☐	☐	Fatigue	☐	☐	Diarrhea
☐	☐	Dizziness	☐	☐	Blood in stool
☐	☐	Night Sweats	☐	☐	Pencil-thin stool
☐	☐	Trouble Sleeping	☐	☐	Hemorrhoids
☐	☐	Appetite Change	☐	☐	Jaundice
			☐	☐	Nausea / Vomiting
☐	☐	Headache	☐	☐	Vomiting of blood
☐	☐	Visual Change	☐	☐	Stomach pain which:
☐	☐	Hearing loss	☐	☐	Occurs after a meal
☐	☐	Earache	☐	☐	Occurs with eating greasy / fried food
☐	☐	Ear Discharge	☐	☐	Awakens you at night
☐	☐	Ringing in Ears	☐	☐	Is relieved by antacids
☐	☐	Nosebleeds			
☐	☐	Sinus Problems	☐	☐	Seasonal / Environmental Allergies
☐	☐	Bleeding Gums	☐	☐	Red, Itchy eyes
☐	☐	Hoarseness	☐	☐	
☐	☐	Sore throat	☐	☐	Easy Bruising
			☐	☐	Rash
☐	☐	Shortness Of Breath:	☐	☐	Change in moles
☐	☐	When doing usual work	☐	☐	Itchy Skin
☐	☐	When climbing one flight of stairs			
☐	☐	Which awakens you at night	☐	☐	Burning when urinating
☐	☐	Cough	☐	☐	Blood in urine
☐	☐	Coughing up blood	☐	☐	Frequent urination
☐	☐	Wheezing	☐	☐	Trouble starting urination
			☐	☐	Trouble holding urine
☐	☐	Chest pain or tightness :			Frequent nighttime urination
☐	☐	When walking fast or up a hill			
☐	☐	After a heavy meal	☐	☐	Muscle Pain
☐	☐	When upset or excited	☐	☐	Joint Pain
☐	☐	That radiates down your arm			
☐	☐	That disappears when you rest	☐	☐	Numbness
☐	☐	Irregular Heartbeats	☐	☐	Weakness
☐	☐	Swelling of ankles	☐	☐	Seizures
			☐	☐	Fainting
☐	☐	Anxiety			
☐	☐	Depression			
☐	☐	Stress			

Immunizations

Date of last tetanus booster:_____ Date of last pneumonia vaccine:_____

Men Only

Please check any of the following symptoms that apply to you

Past	Present	Conditions	Past	Present	Conditions
☐	☐	Loss of sexual function	☐	☐	Prostate Trouble
☐	☐	Discharge from penis	☐	☐	Sexually Transmitted disease
☐	☐	Lump in testicles	☐	☐	Surgery on private parts

If you are sexually active, do you use condoms? Yes No

Women Only

Please check any of the following symptoms that apply to you.

Past	Present	Conditions	Past	Present	Conditions
☐	☐	Bleeding between periods	☐	☐	Abnormal pap smear
☐	☐	Heavy periods	☐	☐	Breast discharge
☐	☐	Extreme menstual periods	☐	☐	Breast lumps
☐	☐	Unusual vaginal discharge	☐	☐	Painful intercourse
☐	☐	Sexually transmitted disease	☐	☐	Hot flashes

Menstrual History		Obstetric History	
Date of last mestrual period:	_____	# of Times Pregnant:	_____
Age at first period:	_____	# of Live Births:	_____
Length of period:	_____	# of Still Born Deliveries:	_____
Number of days between periods:	_____	# of Miscarriages:	_____
Age when periods stopped:	_____	# of Abortions:	_____
		# of Caesarean sections:	_____
		Complications of pregnancy:	_____
Date of last Pap smear:	_____	Date of Last Mammogram:	_____
Was it Normal?	Yes No	Was it Normal?	Yes No

If you are sexually active, do you use birth control? Yes No If yes, what type?_____

Are you currently breast feeding? Yes No