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