PATIENT INFORMATION SHEET

SSN#_____ Appointment Date _____

Name _____ Marital Status: S M W D Other
Last First

Address _____
No. Street City, State Zip Code

Home Telephone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Age _____ Date of Birth _____/_____/_____ Spouse's Name: _____

Employer _____ Occupation _____

Health Insurance Co. _____ Source of Referral: _____

Emergency Contact Name: _____ Phone number: _____

Relationship _____

FOR OFFICE USE ONLY

Physician's Initial Orders: Dietary Considerations:_____

Testing: HRI____SVA____GTT____EKG____PROF____PE____SPG____HC___ELG____
PX____MES____VIDEOS____OTHER_____

Breakfast_____Mid-morning_____
Lunch_____
Bus_____ In_____Out_____
Afternoon _____Leaves work_____
Dinner_____In _____Out_____
Night snacks_____
Before bedtime_____During night _____
Problems_____
_____Eating disorders_____

Name: _____ Date: _____

PATIENT'S HISTORY AND HEALTH QUESTIONNAIRE

Please complete the following as accurately as possible. The doctor will go over the answers with you.

FAMILY HISTORY:

Father: Condition of health _____ cause of death: _____ Mother: Condition of health _____ cause of death: _____ Number of brothers: Living ____ Deceased ____ Cause of death: _____ Number of sisters: Living ____ Deceased ____ Cause of death: _____ Number of children: Boys: _____ ages: _____ Girls: _____ ages: _____ All healthy: _____ Any deceased? _____	Have any members of your family ever had the following? If so, please circle below. Diabetes Tuberculosis Headaches Epilepsy Cancer High Blood Pressure Stroke Allergy Stomach problems Nervous trouble Blood disease Goiter Arthritis Obesity Kidney disease Liver disease Thyroid disease Alcohol/drug abuse Other

PATIENT HISTORY:

ALLERGIES: Please list any Allergies or severe reaction to medicines, food, plants, chemicals, etc.:

_____

_____

_____

_____

MEDICATIONS: Are you taking any medications (prescription or non-prescription), vitamins, supplements, herbs, sleeping pills, or aspirins? If so, please give name of drug, amount taken, how often and how long you have been taking it.

_____ _____

_____ _____

_____ _____

_____ _____

Gynecologic History (women only):

Date last period:_____ Now occurs about every _____ days

Duration:_____ Any abnormalities found?_____

Flow:_____ Painful?_____

Hot flashes?_____ Irregular? _____

Number of pregnancies: _____ Spotting between periods? _____

Breast trouble? _____Do you perform monthly breast exams?_____

Date of last gynecologic exam _____

PATIENT MEDICAL HISTORY (PLEASE CIRCLE):

Respiratory

Sinus trouble
Allergies/Hay fever
Asthma
Shortness of breath
Bronchitis
Tuberculosis
Pneumonia
Emphysema
Frequent colds

Head/Neck

Headaches/Migraines
Cataracts
Tonsillitis
Fits or convulsions
Paralysis
Fainting
Unconsciousness
Goiter
Thyroid disease
Dizziness

Cardiac/Circulatory

Rheumatic fever
Heart trouble
Palpitations
High or low blood pressure
Chest pains
Phlebitis
Varicose veins

Genito/Urinary

Bladder trouble
Kidney trouble
Kidney stones
Sexually transmitted disease
Urinary tract infection
Frequent urination
Pain or burning with urination

Gastro/Intestinal

Abdominal pain
Gerd
Irritable bowel syndrome
Ulcer
Gall stones
Liver trouble
Jaundice
Hepatitis
Constipation
Parasites
Constipation
Diarrhea
Colitis
Hemorrhoids
Hiatus hernia

General

Skin
Anemia
Serious injuries
Surgeries
Back pain
Measles
Mumps
Chicken pox
Cancer or Tumors
Arthritis
Sleep problems
Polio
Diabetes
Hypoglycemia
High cholesterol
Gout
Edema
Leg cramps
Mononucleosis
Alcoholism/Drug addiction
Anorexia
Bulimia
Other

When was your last physical exam? _____ Any abnormalities found? _____

Date of last dental visit: _____ Date of last chest x-ray: _____

Date of last tetanus injection: _____ Date of last electrocardiogram: _____

Are you under any medical treatment now? _____

Do you presently smoke cigarettes? Y N How many packs a day? _____

If not presently but in the past, indicate no. of years & no. of packs per day:

_____