# PATIENT INFORMATION SHEET

NAME: _____ DOB: _____ DATE: _____

ALLERGIES: _____

**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.**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**PERSONAL MEDICAL HISTORY:** (Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| ADHD | Bleeding Problems | GERD (Acid Reflux) | Hepatitis | Psoriasis |
| Alcoholism | Cancer:_____ | Glaucoma | IBS (Irritable Bowl) | Pulmonary Embolism |
| Allergies, Seasonal | Headaches | Heart Disease | Lupus | Rheumatoid Arthritis |
| Anemia | Crohn's Disease | Heart Attack | Liver Disease | Seizure Disorder |
| Anxiety | COPD/Emphysema | Hiatal Hernia | Macular Degeneration | Sleep Apnea |
| Arrhythmia | Dementia | High Blood Pressure | Neuropathy | Stroke |
| Arthritis | Depression | Kidney Stones | Osteopenia/Osteoporosis | Thyroid Disorder |
| Asthma | Diabetes: 1 or 2 | Kidney Disease | Parkinson's Disease | Ulcerative Colitis |
| Bipolar | Diverticulitis | High Cholesterol | Narrowed Blood Vessels | |
| Bladder Problems | DVT (Blood Clot) | HIV | Peptic Ulcer | |

**Other medical problems not listed above:**

_____

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

_____

**Health Screening History:** Please list all health screenings as applicable.

| | | |
|---|---|---|
| Last Menstrual Period Date: _____ | ☐ Normal ☐ Abnormal | |
| Colonoscopy Date: _____ | ☐ Normal ☐ Abnormal | Location Completed: _____ |
| Mammogram Date: _____ | ☐ Normal ☐ Abnormal | Location Completed: _____ |
| Dexa (Bone Density Scan) Date: _____ | ☐ Normal ☐ Abnormal | Location Completed: _____ |
| Pap Smear Date: _____ | ☐ Normal ☐ Abnormal | Location Completed: _____ |

## SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any problems that affect your communication? ☐ Vision Concerns ☐ Hearing Concerns

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Current living situation (Check all that apply): ☐ Single Family Household ☐ Multi-generational Household ☐ Houseless

☐ Shelter ☐ Skilled Nursing Facility ☐ Other:_____

Smoking/Tobacco Use: ☐ Never ☐ Past ☐ Current Type: _____ Amount/Day: _____ Number of Years: _____

*Continued on the other side.*

Alcohol: ☐ Never ☐ Past ☐ Current Drinks/Week: _____

Recreational Drug Use: ☐ Never ☐ Past ☐ Current Type: _____

Are you sexually active? ☐ Yes ☐No

How would you describe your sexual orientation? ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual

☐ Don't Know/Unknown ☐ Choose Not To Disclose

What is your current gender identity? ☐ Male ☐ Female ☐ Transgender Male (female-to-male)

☐ Transgender Female (male-to-female) ☐ Genderqueer (neither exclusively male or female) ☐ Choose Not To Disclose

What sex were you assigned at birth? ☐ Male ☐ Female

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Do you have little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify

Have you been feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

## FAMILY HISTORY:

**FATHER:** Living: Age _____ Deceased: Age _____

| | | | | |
|---|---|---|---|---|
| Alcoholism | Bipolar Disorder | Depression | High Cholesterol | Osteoporosis |
| Anemia | Cancer: _____ | Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (Blood Clot) | Kidney Disease | Thyroid Disorder |
| Arthritis | Dementia | Heart Disease | Migraines | |

Other: _____

**MOTHER:** Living: Age _____ Deceased: Age _____

| | | | | |
|---|---|---|---|---|
| Alcoholism | Bipolar Disorder | Depression | High Cholesterol | Osteoporosis |
| Anemia | Cancer: _____ | Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (Blood Clot) | Kidney Disease | Thyroid Disorder |
| Arthritis | Dementia | Heart Disease | Migraines | |

Other: _____

**SIBLINGS:** _____

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

_____

_____

Patient Signature: _____