

PATIENT INFORMATION SHEET

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

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date: _____	Normal Abnormal
Mammogram	Yes/No Date: _____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date: _____	Normal Abnormal
Pap	Yes/No Date: _____	Normal Abnormal

Other medical problems not listed above:

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

SOCIAL / CULTURAL HISTORY:

Education Level: Elementary High School Vocational College Graduate / Professional

Are there any vision problems that affect your communication? Yes No

Are there any hearing problems that affect your communication? Yes No

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 Homeless Shelter Skilled Nursing Facility Other: _____

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

Alcohol: Current Past Never Drinks/week: _____

Recreational Drug Use: Current Past Never Type: _____

Are you sexually active? Yes No

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: _____ Date: _____