# PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE:_____

ALLERGIES:_____

**SOCIAL HISTORY:**

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____

Alcohol: Currently Past Never Drinks/day:_____

**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.**

| Medications | OTC and vitamins |
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**PERSONAL MEDICAL HISTORY:** (Please circle/fill in all that apply)

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

| | | |
|---|---|---|
| Last Menstrual Period | Yes/No Date:____ | Normal Abnormal |
| Colonoscopy | Yes/No Date:____ | Normal Abnormal |
| Mammogram | Yes/No Date:____ | Normal Abnormal |
| Dxa (Bone Density) | Yes/No Date:____ | Normal Abnormal |

**Other medical problems not listed above:**

_____

_____

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

_____ _____

_____ _____

_____ _____

**FAMILY HISTORY:**

**FATHER:** Living: Age_____ Deceased: Age_____

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|---|---|---|---|---|
| Alcoholism | Blood Cancer | Migraines | Bipolar | Osteoporosis |
| COPD/Emphysema | Skin Cancer | Colon Cancer | High Cholesterol | |
| Stroke | Heart Disease | Lymph Cancer | Thyroid disorder | |
| Anemia | Asthma | Breast Cancer | Dementia | |
| Blood Clot/DVT | Depression | Kidney Disease | Prostate Cancer | |
| Arthritis | High Blood Pressure | Diabetes 1 or 2 | Thyroid Cancer | |

Other:_____

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

| | | | | |
|---|---|---|---|---|
| Alcoholism | Breast Cancer | Migraines | Bipolar | Osteoporosis |
| COPD/Emphysema | Blood Cancer | Colon Cancer | High Cholesterol | |
| Stroke | Heart Disease | Skin Cancer | Thyroid disorder | |
| Anemia | Asthma | Lymph Cancer | Dementia | |
| Blood Clot/DVT | Depression | Kidney Disease | Ovarian Cancer | |
| Arthritis | High Blood Pressure | Diabetes 1 or 2 | Thyroid Cancer | |

Other:_____

**Siblings:**_____

_____

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

_____

_____

Patient signature:_____ Date:_____

Provider reviewed:_____ Date:_____