

**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

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

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### **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:**

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

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_