PATIENT INFORMATION FORM

The following information will be kept in restricted confidence, released only with your authorization.

Patient Name: _____ **Date:** _____

PERSONAL HISTORY

Please check past or present history of the following conditions:

Past	Present	Condition
GENERAL HEALTH		
☐	☐	fatigue
☐	☐	fever
☐	☐	unexpected weight loss or gain
EYES		
☐	☐	blurred vision
☐	☐	double vision
☐	☐	cataracts
☐	☐	glaucoma
HEAD/NECK		
☐	☐	hay fever (pollen allergy)
☐	☐	hearing loss
☐	☐	neck pain
☐	☐	sinusitis/sinus problems
CARDIOVASCULAR		
☐	☐	circulatory problems
☐	☐	coronary heart disease
☐	☐	congestive heart failure
☐	☐	arrhythmias (irregular heartbeat)
☐	☐	heart valve conditions/heart murmur
☐	☐	high blood pressure
☐	☐	high cholesterol
RESPIRATORY		
☐	☐	asthma
☐	☐	COPD/emphysema
☐	☐	cough
☐	☐	pneumonia
☐	☐	shortness of breath
☐	☐	TB (active or exposure)
☐	☐	TB skin test positive
BREAST		
☐	☐	abnormal mammograms
☐	☐	breast lumps
☐	☐	breast biopsies
GASTRO-INTESTINAL		
☐	☐	colon polyps
☐	☐	constipation
☐	☐	diarrhea
☐	☐	diverticulosis/diverticulitis
☐	☐	hemorrhoids
☐	☐	hernia
☐	☐	hepatitis
☐	☐	history of jaundice or hepatitis
☐	☐	irritable bowel syndrome
☐	☐	liver disease
☐	☐	peptic ulcers

Past	Present	Condition
GENITAL & REPRODUCTIVE		
☐	☐	abnormal Pap Smears (cervical dysplasia)
☐	☐	genital warts
☐	☐	infertility (difficulty getting pregnant)
☐	☐	STD or VD (herpes, gonorrhea, chlamydia, syphilis)
URINARY		
☐	☐	incontinence (losing control of urine)
☐	☐	kidney disease
☐	☐	prostate enlargement (BPH)
☐	☐	slow urine stream
☐	☐	frequent urination
MUSCULOSKELETAL		
☐	☐	arthritis
☐	☐	gout
☐	☐	joint pains
☐	☐	muscle aches
SKIN & LYMPH NODES		
☐	☐	eczema
☐	☐	lymph node swelling/disorder
☐	☐	other skin disorders
NEURO		
☐	☐	headaches
☐	☐	seizures/epilepsy
☐	☐	stroke
PSYCHIATRIC		
☐	☐	ADD/ADHD
☐	☐	alcohol/drug problems
☐	☐	anxiety/panic attacks
☐	☐	depression
☐	☐	eating disorder (anorexia/bulimia)
☐	☐	insomnia
ENDOCRINE		
☐	☐	diabetes
☐	☐	thyroid problems
HEME-ONC & IMMUNOLOGY		
☐	☐	AIDS/HIV
☐	☐	anemia
☐	☐	blood clots
☐	☐	cancer
☐	☐	easy bleeding
☐	☐	easy bruising
☐	☐	sickle cell anemia
☐	☐	transfusions (year)

HEALTH MAINTENANCE

Date of last cholesterol testing: : total cholesterol _____ LDL _____ HDL _____ triglycerides _____
Dates of last vaccines: influenza: Pneumovax: Tetanus:
Dates of last Mammogram: Pap Smear: Bone density Test:
Dates of last colonoscopy (or any colon scope): Result if known: Any polyps?
FOR MEN: Date of last rectal exam: Date of last PSA test: (value if known: _____)
Dates of last stress test of heart: Result if known: ☐ ☐ ☐ ☐ **Type of stress test (treadmill / chemical / nuclear / echo)**