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)			

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MEDICAL CONDITIONS (any that require(d) medications or monitoring by health care professionals)

Condition	Date Diagnosed	Type of Treatment Received (for example Medication, Hospitalization, Chemotherapy, Radiation, etc.)	Date Resolved

SOCIAL HISTORY

What is your occupation?	
Do you regularly exercise? Yes No **(Type of exercise _____.)**	**Average # of times per week _____.** **Average # of minutes per session _____.**
Do you regularly drink alcohol? Yes No	**Average # per day _____. Circle type: wine / beer / hard liquor** **Average # per week _____.**
Do you drink caffeinated beverages? Yes No	**Average # per day _____. Circle type: coffee / tea / soda**
Do you currently smoke? Yes No	**Age started _____. Average # of packs per day _____.**
Are you a former smoker? Yes No	**Age started _____. Age quit smoking _____.** **Average # of packs per day _____.**
Ever use recreational drugs? Yes No	**Type _____. Circle: current use / past use**

FAMILY HISTORY

Relative	Medical Problems / Cause of Death	If deceased, age at death
Mother		
Father		
Sisters		
Brothers		
Children		
Grandmother	**Maternal: Paternal:**	**Mat: Pat:**
Grandfather	**Maternal: Paternal:**	**Mat: Pat:**
Aunts	**Maternal: Paternal:**	**Mat: Pat:**
Uncles	**Maternal: Paternal:**	**Mat: Pat:**

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PRIOR SURGERIES

Type of Surgery	Date of Surgery

MEDICATIONS (Please also include over-the-counter and herbal medications.)

Medication	Dose	Frequency	Date when Medication Begun

ALLERGIES

DRUGS / FOODS	REACTIONS