**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.**

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**PERSONAL MEDICAL HISTORY:** (Please circle all that apply)

ADHD Diverticulitis Kidney Stones Sleep Apnea

Alcoholism DVT (Blood Clot) Liver Disease Stroke

Allergies, Seasonal GERD (Acid Reflux) Bipolar (MI) Thyroid Disorder Arrhythmia (irregular heart beat)

Anemia Glaucoma Lupus Ulcerative Colitis Arthritis

Anxiety Heart Attack Macular Degeneration

|  |  |  |
| --- | --- | --- |
| Last MenstrualPeriod | Date: | NormalAbnormal |
| Colonoscopy | Yes/NoDate:\_  | NormalAbnormal |
| Mammogram | Yes/NoDate:\_  | NormalAbnormal |
| DEXA (BoneDensity) | Yes/NoDate:\_ | NormalAbnormal |
| Pap | Yes/NoDate:\_  | NormalAbnormal |

Asthma Heart Disease Neuropathy

Bladder Problems / Incontinence Headaches Osteopenia/Osteoporosis

Bleeding Problems Hepatitis Parkinson’s Disease

Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hiatal Hernia Peptic Ulcer

Crohn’s Disease High Blood Pressure Peripheral Vascular Disease

COPD/ Emphysema High Cholesterol Psoriasis

Dementia HIV Pulmonary Embolism (PE)

Depression Irritable Bowel Syndrome Rheumatoid Arthritis

Diabetes: 1 or 2 Kidney Disease Seizure Disorder

**Other medical problems not listed above:**

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

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**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 | ☐ Multi-generational | ☐ Homeless | ☐ Shelter | ☐ Skilled Nursing | ☐ Other: |
| Household | Household |  |  | Facility |  |

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 Nephrologist, Dentist, etc.)

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