# 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 | |

| | | |
|---|---|---|
| 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 |

| | | |
|---|---|---|
| Headaches | Kidney Stones | Psoriasis |
| Crohn's Disease | Kidney Disease | Pulmonary Embolism (PE) |

**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: _____

*Continued on other side.*

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):

_____

_____

## 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:**

_____

_____

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

_____

_____

Patient Signature: _____ Date: _____