PATIENT INFORMATION

Name: ______________________________ DOB: ____________________

Advance Directive

Do you have a Living Will / DNR? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

If yes: ______________________________

Would you like information regarding Advance Directive? ☐ Yes ☐ No

Chief Complaint (Reason for Visit): ______________________________

ALLERGIES ☐ No Known Drug Allergies

Medication: ____________________ Reaction: ____________________

Medication: ____________________ Reaction: ____________________

Medication: ____________________ Reaction: ____________________

Other (latex, adhesive, food, environment): ______________________________

Other (latex, adhesive, food, environment): ______________________________

MEDICATIONS ☐ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

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PATIENT INFORMATION

Name: ______________________________ DOB: ______________
Last First MI

PERSONAL MEDICAL HISTORY

Please check all diagnoses that apply to you and add notes as needed.

Condition	Yes	No	Condition	Yes	No
AIDS	☐ Yes	☐ No	Hepatitis - Type: ____	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Angina (Heart pain)	☐ Yes	☐ No	Hyperlipidemia (High cholesterol)	☐ Yes	☐ No
Arrhythmia/Palpitations	☐ Yes	☐ No	Hypertension (High blood pressure)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No	Long-Term Steroid Use	☐ Yes	☐ No
Bleeding disorder/tendency	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	MI (Heart attack) - Date: ____	☐ Yes	☐ No
Bone Loss - DEXA: ____ Date	☐ Yes	☐ No	Motor Vehicle Accident	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Oxygen Use	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Chronic Kidney Disease	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Connective Tissue Disorder	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
CVA/Stroke	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Diabetes - Type:	☐ Yes	☐ No	Seasonal Allergies: ____	☐ Yes	☐ No
Dialysis (hemodialysis or peritoneal)	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Disabilities: ____	☐ Yes	☐ No	Sinusitis, recurrent	☐ Yes	☐ No
Diverticulitis	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Ear Infection, recurrent	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Environmental/Food Allergies: ____	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	UTI (Bladder infections)	☐ Yes	☐ No
Genetic/Congenital Condition: ____	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No
GERD (Heartburn)	☐ Yes	☐ No	Other Conditions: ____		
GI Bleeding	☐ Yes	☐ No	____		
Glaucoma	☐ Yes	☐ No	____		
Gunshot Wound	☐ Yes	☐ No	Date of last dental exam: ____		
Head Injury/Concussion	☐ Yes	☐ No	Date of last eye exam: ____		
Hearing Deficit	☐ Yes	☐ No	**Date of last colonoscopy:** ____		
Heart Disease	☐ Yes	☐ No	Doctor: ____		
Heart Failure	☐ Yes	☐ No	History of colon polyps	☐ Yes	☐ No

Name: ______________________________ DOB: ______________
Last First MI mm/dd/yyyy

SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? ☐ Yes ☐ No

Additional Personal Medical History

____

____

____

FEMALE PATIENTS ONLY

☐ Abnormal Pap smear
☐ Other GYN history (indicate below)
Age of first menstrual period: ________
Date of last menstrual period: ________
Age of menopause: ________

Form of contraception (if any): ________
Last mammogram: ________
Last Pap smear: ________
Currently pregnant? ☐ Yes ☐ No
Currently breastfeeding? ☐ Yes ☐ No

Planning pregnancy? ☐ Yes ☐ No
Number of Pregnancies: ________
Number of Deliveries: ________
Number of Elective abortions: ________
Number of Miscarriages: ________

SOCIAL HISTORY

Tobacco Use: ☐ None Quit Date: ________
☐ Pipe/Cigar ☐ Cigarettes Packs/Day: ________ Number of years smoked: ________
☐ Smokeless tobacco ☐ Electronic or E-Cigarette ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ Trying to cut down ☐ In recovery Amount per week: ________

Drug Use: ☐ None ☐ Past Use ☐ Current
How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?
☐ None ☐ One or more
☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club
Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

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Name: ______________________ (Last) ______________________ (First) ____ (MI) DOB: ______________ (mm/dd/yyyy)

Sexual Activity: ☐ Not active ☐ Active Number of lifetime sexual partners: ________ ☐ Men ☐ Women ☐ Both

Do you have a caregiver? ☐ Yes ☐ No

Name: ______________________ Relationship: ______________________

Diet: ☐ Well Balanced ☐ Diabetic ☐ Vegetarian ☐ Fast food/Fats/Carbs
☐ Weight Loss Products ______________________ ☐ Vitamins/Herbs

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt. Training ☐ Stretch/Balance
☐ Twenty minutes/day exercise ☐ Exercise three times weekly ☐ Aerobic/Cardiac

With whom do you live? ☐ Alone ☐ Children ☐ Spouse/Partner ☐ Parents ☐ Assisted Living: ____________

Education: ☐ GED ☐ High School ☐ Did not complete High School ☐ College ☐ Advanced Degree ☐ Technical/Trade

Occupation: ______________________

Leisure activities: ______________________

Religion: ______________________

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector in home

Abuse

I feel safe at home: ☐ Yes ☐ No

Is there anyone you are afraid of? ☐ Yes ☐ No

Do you have a history of abuse? ☐ Yes ☐ No

TRAVEL

In the last 30 days, have you traveled to any foreign countries? ☐ Yes ☐ No List: ______________________

IMMUNIZATIONS

Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis: ________ (mm/dd/yy) Influenza: ________ (mm/dd/yy) Shingles: ________ (mm/dd/yy) Meningitis: ________ (mm/dd/yy)

Hepatitis A: ________ (mm/dd/yy) / ________ (mm/dd/yy) Hepatitis B: ________ (mm/dd/yy) / ________ (mm/dd/yy) / ________ (mm/dd/yy)

HPV: ________ (mm/dd/yy) / ________ (mm/dd/yy) / ________ (mm/dd/yy) Pneumococcal 13 or 23: ________ (mm/dd/yy) Other: ________

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION

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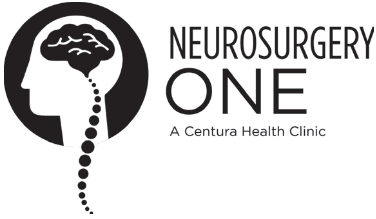
Name: ____ DOB:____________________
Last First MI mm/dd/yyyy

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, if known.

Relationship	Name	Status	No Known Problems	Alcohol abuse	Asthma	Blood clots	Breast cancer	Colon cancer	Prostate cancer	Other cancer(s)	Dementia	Diabetes	Heart disease	High blood pressure	High cholesterol	Kidney disease	Liver disease	Lung disease	Mental Illness	Ovarian Cancer	Stroke	Thyroid condition(s)	Other:____	Other:____	Other:____
Mother		☐ Alive ☐ Deceased																							
Father		☐ Alive ☐ Deceased																							
Sister		☐ Alive ☐ Deceased																							
Brother		☐ Alive ☐ Deceased																							
Son		☐ Alive ☐ Deceased																							
Daughter		☐ Alive ☐ Deceased																							
Maternal Grandmother		☐ Alive ☐ Deceased																							
Maternal Grandfather		☐ Alive ☐ Deceased																							
Paternal Grandmother		☐ Alive ☐ Deceased																							
Paternal Grandfather		☐ Alive ☐ Deceased																							
Other:______		☐ Alive ☐ Deceased																							
Other:______		☐ Alive ☐ Deceased																							
Other:______		☐ Alive ☐ Deceased																							

Are you adopted?: ☐ Yes ☐ No



NAME (Last, First): ___________________________
DATE OF BIRTH: ________ / ________ / ________

PATIENT DIRECTIVES FOR RELEASE AND COMMUNICATION OF INFORMATION

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information. (_____) ______-__________ ◻ Home ◻ Cell ◻ Work

Can confidential messages (i.e. appointment reminders) be left on the above telephone's answering machine or voice mail? ◻ YES ◻ NO

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations)

Name: ____________________________________ Phone: (_____) ______-__________

Name: ____________________________________ Phone: (_____) ______-__________

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY

Name: _____________________________________ Phone: (_____) ______-__________

Name: _____________________________________ Phone: (_____) ______-__________

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*I am fully aware that a cell phone is not a secure and private line.

**We will mail all written communications and billing statements to the address provided on your "Patient Information Form", unless otherwise directed.

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PRINTED PATIENT NAME: ____

PATIENT/GUARDIAN SIGNATURE _______________________________________

Date: ____________________________