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	Last Menstrual Period Date: Normal Abnormal Colonoscopy Date:___ Yes/No Normal Abnormal Mammogram Yes/No Normal Date: Abnormal Dexa (Bone Density) Yes/No Normal Date: Abnormal Pap Yes/No Normal Date: Abnormal
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	
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

- Always
- Usually
- Sometimes
- Rarely
- Never

• 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:

Updated 3/2022