

PATIENT INFORMATION SHEET

Name: _____ Birthdate: _____

MEDICAL HISTORY: List any current or past medical problems or chronic diseases.

SURGICAL HISTORY: List all surgeries you have had, the year they were done, and the surgeon's name.

MEDICATIONS: List all medicines taken daily, with dose and schedule. Include over the counter meds, vitamins and supplements.

ALLERGIES: List all allergies to medicines or foods and the kind of a reaction you have - rash, hives, swelling, difficulty breathing, etc.

List any other physicians you see and why: _____

HEALTH MAINTENANCE:

Do you smoke cigarettes, cigars, a pipe, or use chewing tobacco? _____ Do you want to quit? _____

If yes, how much per day? _____ Have you smoked in the past? _____ When did you quit? _____

How much alcohol do you drink and how often? _____

List any current or past use of street drugs: _____

Are you sexually active? _____ Number of lifetime partners? _____

What birth control do you use? _____

Are you on a special diet? _____ Describe your typical eating habits: _____

How much caffeine do you drink in a typical day? None _____ 1-2 drinks _____ 3-4 drinks _____ 5 or more drinks _____

Do you take calcium supplements? _____ What dairy products do you consume every day? _____

How frequently are you in the sun? _____ Do you wear sunscreen? _____ Do you use a tanning bed? _____

What is your marital status? _____ How many children do you have? _____

Who lives in your home and what is their relationship to you? _____

Hobbies? _____

How often do you wear your seatbelt? Always _____ Sometimes _____ Never _____

What do you do for exercise, and how often? _____

Highest level of education? _____ Degree? _____

Employment: Full time Part time Student Retired Disabled Unemployed Stay at home parent

What type of work do you do? Employer? _____

FAMILY HISTORY: Are your parents alive? _____ If not, what did they die from, and how old were they?

Mother: _____ Father: _____

Which of your **blood** relatives have had the following diseases? (Check all that apply.)

	Mother	Father	Sister	Brother	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Aunt	Uncle
Heart disease										
High blood pressure										
Asthma										
Stroke										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Prostate Cancer										
Uterine Cancer										
Alcoholism										
Anxiety										
Depression										
Diabetes										
Other Conditions										

PREVENTATIVE HISTORY: When was your last tetanus booster? _____ Pneumonia vaccine? _____

Colonoscopy? _____ Eye exam? _____ Shingles vaccine? _____

FEMALE HISTORY: When was your last menstrual period? _____ When was your first period? _____

When was your last PAP smear? _____ Any history of abnormal PAP smears? _____

When was your last mammogram? _____ Last bone scan? _____

How many times have you been pregnant? _____ How many children do you have? _____