## 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.

| Name of Medication | Strength/Dose (mg) | How often taken | Reason you are taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**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? _____ Birth control? _____

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_____

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? _____