

PATIENT MEDICAL INFORMATION FORM

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ For how long? \_\_\_\_\_

Allergies: Are you allergic to any medicines? Circle one: Yes No If yes, please complete the following:

<u>Medication</u>	<u>Type of Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

Medications: Please list current medicines, inhalers, over the counter medicines, vitamins, and herbals:

<u>Medication</u>	<u>Dose</u>	<u>How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Operations/Hospital Stays: Please list ALL operations and overnight hospital stays (not ER visits):

Operation/Stay: \_\_\_\_\_ Date: \_\_\_\_\_

Operation/Stay: \_\_\_\_\_ Date: \_\_\_\_\_

Operation/Stay: \_\_\_\_\_ Date: \_\_\_\_\_

Social History:

Do you smoke? Yes No If yes, how much per day? \_\_\_\_\_ for how many years? \_\_\_\_\_

Have you ever smoked? Yes No Quit Date \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how often? \_\_\_\_\_ how much? \_\_\_\_\_

Do you take illicit drugs ("street drugs")? Yes No If yes, which drug? \_\_\_\_\_

Do you drink caffeinated beverages? Yes No If yes, how often? \_\_\_\_\_ how much? \_\_\_\_\_

Describe your eating habits: \_\_\_\_\_

Describe your exercise routine: \_\_\_\_\_

What is your sexual preference? Male Female Bisexual

Patient's Name (page 2 of Medical Information): \_\_\_\_\_

**Family History:** Please answer the following questions about your family's health:

Diabetes    Yes    No    If yes, who? \_\_\_\_\_      High blood pressure    Yes    No    If yes, who? \_\_\_\_\_  
Asthma      Yes    No    If yes, who? \_\_\_\_\_      High cholesterol      Yes    No    If yes, who? \_\_\_\_\_  
Heart issues    Yes    No    If yes, who? \_\_\_\_\_      Heart Attack          Yes    No    If yes, who? \_\_\_\_\_  
Stroke        Yes    No    If yes, who? \_\_\_\_\_      Depression/Anxiety    Yes    No    If yes, who? \_\_\_\_\_  
Cancer    Yes    No    If yes, who and what type? \_\_\_\_\_

**Medical History:** Have you ever been diagnosed with or are currently having any of the following symptoms? Please circle all that apply, and when this was an issue for you (date).

**HEENT:**

Headache  
Ear problems  
Nose/sinus problems  
Throat problems

**Musculoskeletal:**

Back problems  
Joint Pain  
Arthritis  
Broken bones  
Osteoporosis

**Endocrine:**

Diabetes  
Thyroid problems  
Tired/sluggish  
Excessive thirst

**Neurologic:**

Seizures/epilepsy  
Stroke  
Loss of strength  
Loss of sensation  
Numbness/tingling  
Multiple Sclerosis

**Respiratory:**

Asthma  
COPD  
Emphysema  
Bronchitis  
Pneumonia  
Pulmonary Embolism

**Gastrointestinal:**

Abdominal Pain  
Constipation  
Diarrhea  
Colitis  
Diverticulitis  
Heartburn/reflux  
Ulcers  
Hemorrhoids  
Change in Bowel Habits

**Genitourinary/GYN:**

Bladder infections  
Kidney stones  
Prostate infections  
Ovary problems  
Uterine problems  
Abnormal Pap smear  
Breast lump

**Blood/Immune:**

Anemia  
Blood clot  
Jaundice  
Lupus  
Liver disease

**Cardiac:**

Chest Pain (Angina)  
Heart Attack  
High Blood Pressure  
High Cholesterol  
Heart Racing  
Palpitations  
Heart Failure  
Pacemaker  
Heart Valve  
Rheumatic Fever

**Skin:**

Hives  
Eczema  
Psoriasis  
Allergic rash

**Psychologic:**

Anxiety  
Depression  
Bipolar disease  
Panic attacks

**Communicable Diseases:** Have you ever had Hepatitis? If yes, what type?    A    B    C

Sexually Transmitted Disease?    Yes    No    If yes, what disease? \_\_\_\_\_

**Cancer:** Have you ever been diagnosed with cancer?    Yes    No    If yes, what kind? \_\_\_\_\_

What treatment did you have? \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

**Concerns to discuss with the doctor:**

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