

Patient Information Sheet

Today's Date: _____

Name: _____
Last First Middle Initial

D/O/B: _____ **Age:** _____ **Sex:** _____

Address: _____
Number Street Name Apt #

City: _____ **State:** _____ **Zip:** _____

Hm ph: _____ **Wk ph:** _____ **Cell Ph:** _____

Emergency Contact Name: _____ **Number:** _____

Medical History

Reason for your visit today: _____

Current Medications: _____

Allergies: _____

Please check the appropriate:

| | You | Family | | You | Family |
|----------------------|-----|--------|-----------------------|-----|--------|
| High Blood Pressure | | | Tuberculosis (TB) | | |
| Heart Disease | | | Mental Problems | | |
| Stroke | | | Alcohol/Drug Problems | | |
| Diabetes | | | Glaucoma | | |
| Asthma/Lung Problems | | | Anemia | | |
| Cancer | | | Kidney Problems | | |
| Other: | | | | | |

Hospitalizations

Have you ever been in the hospital before? _____ Yes _____ No – if yes, please complete chart

| Dates | Reasons |
|-------|---------|
| | |
| | |
| | |
| | |
| | |

Immunizations

(Dates)

Social Habits

(List amounts and frequency of use)

| | |
|---------------------------|------------------|
| Tetanus: | Alcohol: |
| Pneumovax/Pneumonia Shot: | Tobacco: |
| Flu Shot: | Street Drugs: |
| Hepatitis B: | Caffeine: |
| Hepatitis A: | Unprotected Sex: |
| TB Skin Test: | Self-Harm: |

If over age 50:

Date of last sigmoid or colonoscopy: _____ results = normal/abnormal
(circle)

Men over age 50:

Date of last PSA test: _____ results = normal/abnormal
(circle)

Females ONLY:

Date of last Pap smear: _____ results = normal/abnormal
(circle)

Date of last Mammogram: _____ results = normal/abnormal
(circle)