# PATIENT INFORMATION FORM

**The following information will be kept in strict confidence, released only with your authorization.**

**Patient Name: ____________________________________ Date: ______________________**

**Please check if currently having these symptoms:**

**GENERAL:**
- ☐ fatigue
- ☐ fever
- ☐ chills
- ☐ unexpected weight gain
- ☐ unexpected weight loss

**EYES:**
- ☐ blurred vision
- ☐ double vision
- ☐ eye pain
- ☐ loss of vision

**THROAT/NOSE/EARS:**
- ☐ sore throat
- ☐ nasal congestion
- ☐ nasal discharge (clear / discolored)
- ☐ ear pain
- ☐ hearing loss
- ☐ ear ringing
- ☐ nosebleed
- ☐ hay fever(pollen allergy)

**HEART/CIRCULATION**
- ☐ chest pain
- ☐ palpitations
- ☐ leg swelling
- ☐ passing out
- ☐ leg cramps during walking

**RESPIRATORY:**
- ☐ shortness of breath
- ☐ dry cough
- ☐ productive cough
- ☐ wheezing
- ☐ snoring
- ☐ pauses in breathing while sleeping
- ☐ excessive sleepiness

**DIGESTION:**
- ☐ acid reflux
- ☐ abdominal pain
- ☐ nausea
- ☐ vomiting
- ☐ painful swallowing
- ☐ food sticking when swallowing
- ☐ constipation
- ☐ diarrhea
- ☐ blood in stool

**URINARY:**
- ☐ painful urination
- ☐ blood in urine
- ☐ excessive night-time urination, disrupting sleep
- ☐ frequent urination
- ☐ loss of control of urine (leakage)

**FEMALE:**
- ☐ heavy periods
- ☐ irregular periods
- ☐ painful periods
- ☐ last period:____________
- ☐ currently pregnant
- ☐ menopause
- ☐ hot flashes

**MALE:**
- ☐ slow urinary stream
- ☐ urinary hesitancy
- ☐ testicular lump
- ☐ testicular pain
- ☐ erectile problems

**MUSCULOSKELETAL:**
- ☐ joint pains
- ☐ muscle aches
- ☐ neck pain
- ☐ back pain
- ☐ knuckle stiffness in morning

**SKIN / LYMPH NODES:**
- ☐ rash
- ☐ change in mole (either in size or color)
- ☐ lymph node swelling
- ☐ breast lump(s)

**NEURO:**
- ☐ headache
- ☐ dizziness
- ☐ numbness/tingling
- ☐ weakness of arm/leg/face
- ☐ tremor
- ☐ memory loss

**PSYCHIATRY:**
- ☐ low mood
- ☐ crying spells
- ☐ insomnia
- ☐ job/family/financial or social stress
- ☐ anxiety
- ☐ panic attacks
- ☐ excessive worrying
- ☐ suicidal thoughts

**ENDOCRINE**
- ☐ excessive thirst
- ☐ excessive urination
- ☐ cold intolerance
- ☐ heat intolerance

**HEMATOLOGY:**
- ☐ easy bleeding
- ☐ easy bruising
- ☐ easy gum bleeding

## HEALTH MAINTENANCE

**Date of last cholesterol testing:** **total cholesterol:** _______ **LDL** _______ **HDL** _______ **triglycerides** _______

**Dates of last vaccines: influenza:** **Pneumovax:** **Tetanus:** **Zostavax(for Shingles):**

**Dates of last** **Mammogram:** **Pap Smear:** **Bone density Test:**

**Date of last colonoscopy (or any colon scope):** **Result if known:** **Any polyps?**

**FOR MEN: Date of last rectal exam:** **Date of last PSA test:** **(value if known: _______ )**

**Dates of last stress test of heart:** **Result if known:**
**Type of stress test (treadmill / chemical / nuclear / echo)**

## FAMILY HISTORY

| Relative | Medical Problems / Cause of Death | | If deceased, age at death | |
|---|---|---|---|---|
| **Mother** | | | | |
| **Father** | | | | |
| **Children** | | | | |
| **Sisters** | | | | |
| **Brothers** | | | | |
| **Grandfather** | **Maternal:** | **Paternal:** | **Mat:** | **Pat:** |
| **Grandmother** | **Maternal:** | **Paternal:** | **Mat:** | **Pat:** |

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| Past | Present | Condition | Past | Present | Condition |
|---|---|---|---|---|---|
| **EYES** | | | **URINARY** | | |
| ☐ | ☐ | cataracts | ☐ | ☐ | kidney disease |
| ☐ | ☐ | glaucoma | ☐ | ☐ | kidney stone |
| **CARDIOVASCULAR** | | | ☐ | ☐ | prostate enlargement (BPH) |
| ☐ | ☐ | coronary heart disease | **MUSCULOSKELETAL** | | |
| ☐ | ☐ | congestive heart failure | ☐ | ☐ | arthritis |
| ☐ | ☐ | arrhythmias (irregular heartbeat) | ☐ | ☐ | gout |
| ☐ | ☐ | heart valve conditions/heart murmur | **SKIN & LYMPH NODES** | | |
| ☐ | ☐ | high blood pressure | ☐ | ☐ | skin cancer |
| ☐ | ☐ | high cholesterol | ☐ | ☐ | other skin disorders |
| **RESPIRATORY** | | | **NEURO** | | |
| ☐ | ☐ | asthma | ☐ | ☐ | migraines |
| ☐ | ☐ | COPD/emphysema | ☐ | ☐ | seizures/epilepsy |
| ☐ | ☐ | TB , or positive TB skin test | ☐ | ☐ | stroke |
| **BREAST** | | | **PSYCHIATRIC** | | |
| ☐ | ☐ | abnormal mammograms | ☐ | ☐ | ADD/ADHD |
| ☐ | ☐ | breast biopsies | ☐ | ☐ | alcohol/drug problems |
| **GASTROINTESTINAL** | | | ☐ | ☐ | anxiety/panic attacks |
| ☐ | ☐ | colon polyps | ☐ | ☐ | depression |
| ☐ | ☐ | diverticulosis/diverticulitis | ☐ | ☐ | eating disorder (anorexia/bulimia) |
| ☐ | ☐ | hemorrhoids | ☐ | ☐ | long-term insomnia |
| ☐ | ☐ | hernia | **ENDOCRINE** | | |
| ☐ | ☐ | hepatitis (jaundice) | ☐ | ☐ | diabetes |
| ☐ | ☐ | irritable bowel syndrome | ☐ | ☐ | thyroid problems |
| ☐ | ☐ | liver disease | **HEME-ONC & IMMUNOLOGY** | | |
| ☐ | ☐ | peptic ulcers | ☐ | ☐ | AIDS/HIV |
| **GENITAL & REPRODUCTIVE** | | | ☐ | ☐ | anemia |
| ☐ | ☐ | Abnormal Pap Smears (cervical dysplasia) | ☐ | ☐ | blood clots |
| ☐ | ☐ | infertility (difficulty getting pregnant) | ☐ | ☐ | cancer |
| ☐ | ☐ | STD (herpes, gonorrhea, chlamydia, syphilis, genital warts) | ☐ | ☐ | sickle cell anemia |
| | | | ☐ | ☐ | blood transfusion(s) (received blood) |

## SOCIAL HISTORY

| | |
|---|---|
| **Marital status?** | **Single / Married / Divorced / Widowed** |
| **What is your occupation?** | **Job Title:** |
| **Do you regularly exercise? Yes No**<br>**(Type of exercise ___________________________________ )** | **Average # of times per week _____________.**<br>**Average # of minutes per session ____________.** |
| **Do you regularly drink alcohol? Yes No** | **Average # per day _______. Circle type: wine / beer / hard liquor**<br>**Average # per week ______.** |
| **Do you drink caffeinated beverages? Yes No** | **Average # per day ___________. Circle type: coffee / tea / soda** |
| **Do you currently smoke? Yes No** | **Age started _______. Average # of packs per day _______.** |
| **Are you a former smoker? Yes No** | **Age started _______. Age quit smoking _______.**<br>**Average # of packs per day _______.** |
| **Ever use recreational drugs? Yes No** | **Type _________________________. Circle: current use / past use** |

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## MEDICAL CONDITIONS

| Condition | Date Diagnosed | Type of treatment | Date Resolved |
|---|---|---|---|
| | | ☐ med listed below | |
| | | ☐ med listed below | |
| | | ☐ med listed below | |
| | | ☐ med listed below | |
| | | ☐ med listed below | |
| | | ☐ med listed below | |
| | | ☐ med listed below | |

## MEDICATIONS (Please also include over-the-counter and herbal medications.)

| Medication | Dose | Frequency | Date when Medication Began |
|---|---|---|---|
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## PRIOR SURGERIES (not mentioned above)

| Type of Surgery | Date of surgery |
|---|---|
| | |
| | |
| | |

## ALLERGIES

| DRUGS/FOODS | REACTIONS |
|---|---|
| | |
| | |
| | |