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NAME:

GENDER:

DOB:

DATE:

ALLERGIES:

**List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don’t know, please call your pharmacist to confirm.**

**PERSONAL MEDICAL HISTORY:** (Please circle all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| ADHD  | COPD/ Emphysema  | High Cholesterol  | Rheumatoid Arthritis  |
| Alcoholism  | Dementia  | HIV  | Seizure Disorder  |
| Allergies, Seasonal  | Depression  | Hepatitis  | Sleep Apnea  |
| Anemia  | Diabetes: 1 or 2  | Irritable Bowel Syndrome  | Stroke  |
| Anxiety  | Diverticulitis  | Lupus  | Thyroid Disorder  |
| Arrhythmia (irregular heart beat)  | DVT (Blood Clot)  | Liver Disease  | Ulcerative Colitis  |

|  |  |  |
| --- | --- | --- |
| Last Menstrual Period  | Date: \_\_\_\_\_\_\_\_\_  | Normal Abnormal  |
| Colonoscopy  | Yes/No Date:\_\_\_\_  | Normal Abnormal  |
| Mammogram  | Yes/No Date:\_\_\_\_  | Normal Abnormal  |
| Dexa (Bone Density)  | Yes/No Date:\_\_\_\_  | Normal Abnormal  |
| Pap  | Yes/No Date:\_\_\_\_  | Normal Abnormal  |

|  |  |  |
| --- | --- | --- |
|  |  |   |
| Headaches  | Kidney Stones  | Psoriasis  |
| Crohn’s Disease  | Kidney Disease  | Pulmonary Embolism (PE)  |

 Arthritis GERD (Acid Reflux) Macular Degeneration

 Asthma Glaucoma Neuropathy

 Bipolar Heart Disease Osteopenia/Osteoporosis

 Bladder Problems / Incontinence Heart Attack (MI) Parkinson’s Disease

 Bleeding Problems Hiatal Hernia Peripheral Vascular Disease

 Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure Peptic Ulcer

**Other medical problems not listed above:**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:** Please list all prior surgeries and approximate dates performed.

|  |  |
| --- | --- |
|  **SOCIAL / CULTURAL HISTORY:**  |  |
|  Education Level: ☐ Elementary ☐ High School ☐ Vocational  | ☐ College ☐ Graduate / Professional  |
|  Are there any vision problems that affect your communication?  | ☐Yes ☐ No  |
|  Are there any hearing problems that affect your communication?  | ☐Yes ☐ No  |

 Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

 Current Living Situation (Check all that apply):

 ☐ Single Family ☐ Multi-generational ☐ Homeless ☐ Shelter ☐ Skilled Nursing ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Household Household Facility

*Continued on other side. Page 1 of 2*

 Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount/day: \_\_\_\_\_\_\_\_\_\_ Number of Years: \_\_\_\_\_\_\_ Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: \_\_\_\_\_\_\_\_\_\_

 Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you sexually active? ☐Yes ☐ No

 Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

 Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

 Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

 How often do you get the social and emotional support you need?

 ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked “yes” above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAMILY HISTORY:**

 **FATHER:** Living: Age \_\_\_\_\_\_\_\_\_\_\_\_ Deceased: Age \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Alcoholism  | Bipolar Disorder  | Depression  | High Cholesterol  | Osteoporosis  |
| Anemia  | Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Diabetes 1 or 2  | High Blood Pressure  | Stroke  |
| Asthma  | COPD/Emphysema  | DVT (Blood Clot)  | Kidney Disease  | Thyroid Disorder  |
| Arthritis  | Dementia  | Heart Disease  | Migraines  |   |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **MOTHER:** Living: Age \_\_\_\_\_\_\_\_\_\_\_\_ Deceased: Age \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Alcoholism  | Bipolar Disorder  | Depression  | High Cholesterol  | Osteoporosis  |
| Anemia  | Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Diabetes 1 or 2  | High Blood Pressure  | Stroke  |
| Asthma  | COPD/Emphysema  | DVT (Blood Clot)  | Kidney Disease  | Thyroid Disorder  |
| Arthritis  | Dementia  | Heart Disease  | Migraines  |   |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SIBLINGS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List other medical providers you see on a regular basis** (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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