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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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