

PATIENT INFORMATION FORM

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

Patient Name: _____ **DOB:** _____

Please check if currently having these symptoms:

<p><u>GENERAL:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Unexpected weight gain <input type="checkbox"/> Unexpected weight loss <p><u>EYES:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Loss of vision <p><u>THROAT/NOSE/EARS:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Nasal discharge (clear/discolored) <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear ringing <input type="checkbox"/> Nosebleed <input type="checkbox"/> Hay fever (pollen allergy) <p><u>HEART/CIRCULATION</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg swelling <input type="checkbox"/> Passing out <input type="checkbox"/> Leg cramps during walking 	<p><u>RESPIRATORY:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dry cough <input type="checkbox"/> Productive cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Snoring <input type="checkbox"/> Pauses in breathing while sleeping <input type="checkbox"/> Excessive sleepiness <p><u>DIGESTION:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Acid reflux <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Painful swallowing <input type="checkbox"/> Food sticking when swallowing <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <p><u>URINARY:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Excessive night-time urination, disrupting sleep <input type="checkbox"/> Frequent urination <input type="checkbox"/> Loss of control of urine (Leakage) 	<p><u>FEMALE:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Heavy periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Last period: _____ <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Menopause <input type="checkbox"/> Hot flashes <p><u>MUSCULOSKELETAL:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint pains <input type="checkbox"/> Muscle aches <input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Knuckle stiffness in morning <p><u>SKIN/LYMPH NODES:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash <input type="checkbox"/> Change in mole (either in size or color) <input type="checkbox"/> Lymph node swelling <input type="checkbox"/> Breast lump(s) <p><u>ENDOCRINE</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance 	<p><u>MALE:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Slow urinary stream <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Testicular lump <input type="checkbox"/> Testicular pain <input type="checkbox"/> Erectile problems <p><u>NEURO:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Weakness of arm/leg/face <input type="checkbox"/> Tremor <input type="checkbox"/> Memory loss <p><u>PSYCHIATRY:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Low mood <input type="checkbox"/> Crying spells <input type="checkbox"/> Insomnia <input type="checkbox"/> Job/family/financial or social stress <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic attacks <input type="checkbox"/> Excessive worrying <input type="checkbox"/> Suicidal thoughts <p><u>HEMATOLOGY:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Easy gum bleeding
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HEALTH MAINTENANCE

Date of last cholesterol testing: _____ **Total Cholesterol:** _____ **LDL:** _____ **HDL:** _____ **Triglycerides:** _____

Date of last vaccines: **Flu:** _____ **Pneumovax:** _____ **Prevnar-13:** _____ **Tetanus:** _____ **Shingrix:** _____

Date of last mammogram: _____ Pap Smear: _____ Bone density test: _____



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Results if known: _____ Any polyps? _____

last PSA test: _____ (Value if known: _____)

if known: _____

Type of stress test: treadmill chemical nuclear echo

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FAMILY HISTORY

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

CONDITIONS

Past	Present	Condition	Past	Present	Condition
<u>EYES</u>			<u>URINARY</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone
<u>CARDIOVASCULAR</u>			<input type="checkbox"/>	<input type="checkbox"/>	Prostate enlargement (BPH)
<input type="checkbox"/>	<input type="checkbox"/>	Coronary heart disease	<u>MUSCULOSKELETAL</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmias (irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	gout
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve conditions/heart murmur	<u>SKIN & LYMPH NODES</u>		
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Other skin disorders
<u>RESPIRATORY</u>			<u>NEURO</u>		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	TB, or positive TB skin test	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<u>BREAST</u>			<u>PSYCHIATRIC</u>		

Abnormal mammograms

Breast biopsies

GASTROINTESTINAL

Colon polyps

Diverticulosis/Diverticulitis

Hemorrhoids

Hernia

Hepatitis (jaundice)

Irritable bowel syndrome

Liver disease

Peptic ulcers

GENITAL & REPRODUCTIVE

Abnormal pap smears (cervical dysplasia)

Infertility (difficulty getting pregnant)

STD (herpes, gonorrhea, chlamydia,

ADD/ADHD

Alcohol/drug problems

Anxiety/panic attacks

Depression

Eating disorder (anorexia/bulimia)

Long-term insomnia

ENDOCRINE

Diabetes

Thyroid problems

HEME-ONC & IMMUNOLOGY

AIDS/HIV

Anemia

Blood clots

cancer

Sickle cell anemia

Blood transfusion



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SOCIAL HISTORY

Marital Status?	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
What is your occupation?	Job Title: _____
Do you regularly exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of exercise: _____	Average # of times per week _____ Average # of minutes per session _____
Do you regularly drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average # per day _____ Type: <input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Hard liquor Average # per week _____
Do you drink caffeinated beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average # per day _____ Average # of packs per day _____ Type: <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda
Do you currently smoke? Or vape? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age started _____ Age quit smoking _____
Are you a former smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age started _____ Age quit smoking _____ Average # of packs per day _____

Ever use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____	<input type="checkbox"/> Current use <input type="checkbox"/> Past use
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MEDICAL CONDITIONS

Condition	Date Diagnosed	Type of Treatment	Date Resolved
		<input type="checkbox"/> Med listed below	
		<input type="checkbox"/> Med listed below	
		<input type="checkbox"/> Med listed below	
		<input type="checkbox"/> Med listed below	
		<input type="checkbox"/> Med listed below	
		<input type="checkbox"/> Med listed below	

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

Medication	Dose	Frequency	Date when Medication Began



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_____ Address or phone #: _____

f any): _____

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PRIOR SURGERIES (not mentioned above)

Type of Surgery	Date of Surgery

ALLERGIES

DRUGS/FOODS	REACTIONS

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