Date: _____

PATIENT INFORMATION FORM

Name: _____ DOB: _____

In order to help you better, please take a moment to provide this information.

HISTORY OF PRESENT ILLNESS

What is the major reason for your visit today?

_____

_____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please ☒ all problem areas and explain any symptoms on the following page.

General

- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Fever, chills
- ☐ Swollen glands

Skin

- ☐ New / change in mole
- ☐ Rash / itching / easy bruising

Breast

- ☐ Breast lump / pain / nipple discharge

Ears/Nose/Throat

- ☐ Nosebleeds, trouble swallowing
- ☐ Frequent sore throats, hoarseness
- ☐ Hearing loss / ringing in ears

Eyes

- ☐ Change in vision / eye pain / redness

Cardiovascular

- ☐ Chest pain / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ Other _____

Respiratory

- ☐ Cough / wheeze
- ☐ Loud snoring / altered breathing during sleeping
- ☐ Short of breath with exertion

Gastrointestinal

- ☐ Heartburn / reflux / indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation / diarrhea
- ☐ Nausea or vomiting

Genitourinary

- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nighttime urination or increased frequency
- ☐ Concern with sexual function

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle / joint pain

Neurological

- ☐ Headache
- ☐ Memory loss
- ☐ Fainting / dizziness
- ☐ Numbness / tingling
- ☐ Unsteady gait
- ☐ Frequent falls

Psychiatric

- ☐ Anxiety
- ☐ Stress / irritability
- ☐ Depression
- ☐ Sleep problems
- ☐ Lack of concentration

Women Only

- ☐ Pre-menstrual symptoms
- ☐ Problems with menstrual periods
- ☐ Hot flashes / night sweats

MORE ON BACK

Please explain in detail any of the symptoms you checked on the previous page.

What are you feeling?	*When did it start?*	*Location of symptoms?*	*Severity and duration?*	*What makes it better/worse and the course over time?*

For Female Patients

Breast Examination (Date of last test): _____ Mammogram (Date of last test): _____

Pap Smear (Date of last test): _____ *Any?* ☐ Pain after intercourse ☐ Bleeding after intercourse

☐ Flushing/menopause ☐ Diminished libido ☐ Infertility/infertility problems ☐ Other problems: _____

_____ Date of last period: _____

Flow? ☐ Regular ☐ Irregular ☐ Heavy ☐ Moderate ☐ Light ☐ Pain/cramps w/ flow Length of cycle: _____

No. of pregnancies: ____ Live births: ____ Miscarriages: ____ Birth control method: _____

Age of menopausal onset: _____

Male Patients

Any problems with sexual function or urinary function?

_____

_____

HEALTH HISTORY

Are you being treated for, or have you ever had, any of the following health conditions?

Please ☒ if applicable. Additional space is provided below for details or other health conditions not listed.

☐ Allergies	☐ Diverticulosis/diverticulitis	☐ Heart valvular disease	☐ Osteoporosis/osteopenia
☐ Anemia	☐ Eating disorder	☐ Hemorrhoids	☐ Peptic ulcer(s)
☐ Aneurysm	☐ Emphysema	☐ Hepatitis Type: _____	☐ Peripheral vascular disease
☐ Arthritis (Osteoarthritis)	☐ Fertility issues	☐ Herpes Type: _____	☐ Pneumonia
☐ Arthritis (Rheumatoid)	☐ Gastroesophageal reflux	☐ High Blood Pressure	☐ Prostate problems
☐ Asthma	☐ Glaucoma	☐ HIV/AIDS	☐ Seizure disorder
☐ Atrial fibrillation	☐ Goiter	☐ Hyperthyroidism	☐ Sleep apnea
☐ Bleeding problem	☐ Gout	☐ Hypothyroidism	☐ Stroke
☐ Blood clots	☐ Headaches (Migraine)	☐ Irritable bowel	☐ TIA
☐ Bronchitis	☐ Heart arrhythmia	☐ Kidney disease	☐ Tremors
☐ Cancer Type: _____	☐ Heart coronary disease	☐ Kidney stones	☐ Tuberculosis
☐ Colitis	☐ Heart failure	☐ Lupus (SLE)	☐ Urinary problems
☐ Diabetes (Adulthood onset)	☐ Heart pacemaker	☐ Neuropathy	☐ Varicose veins
☐ Diabetes (Childhood onset)	☐ Heart stents	☐ Nervous system disease	☐ Weight problems

List additional information and other health conditions not listed above:

_____

_____

Have you ever had a past surgical history or serious injuries?

What?	*Treatment?*	*Approximate Date?*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Birthplace: _____ Relationship status: _____

Occupation: _____

Have you ever been exposed to toxic chemicals or radiation? ☐ Yes ☐ No

MORE ON BACK

Have you ever smoked cigarettes regularly? ☐ Yes ☐ No Have you stopped? ☐ Yes ☐ No

If *Yes*, how many packs? ______________________________ How many years? ____________________________

Do you drink alcohol? ☐ Yes ☐ No

If *Yes*, how much? ______________________________ How often? ______________________________________

Do you exercise regularly? ☐ Yes ☐ No

If *Yes*, how much? ____ How often? ____________________________

How would you describe your diet? ____

FAMILY HISTORY

			Medical Conditions
Maternal Grandmother		☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Maternal Grandfather		☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Paternal Grandmother		☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Paternal Grandfather		☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Mother		☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Father		☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Sibling	☐ Female ☐ Male	☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Sibling	☐ Female ☐ Male	☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Sibling	☐ Female ☐ Male	☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Sibling	☐ Female ☐ Male	☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	
Sibling	☐ Female ☐ Male	☐ Alive (*Age:* ____) ☐ Deceased (*Age:* ____)	

CONTINUES…………

Child	□ Female □ Male	□ Alive (*Age:* ____) □ Deceased (*Age:* ____)	
Child	□ Female □ Male	□ Alive (*Age:* ____) □ Deceased (*Age:* ____)	
Child	□ Female □ Male	□ Alive (*Age:* ____) □ Deceased (*Age:* ____)	
Child	□ Female □ Male	□ Alive (*Age:* ____) □ Deceased (*Age:* ____)	
Child	□ Female □ Male	□ Alive (*Age:* ____) □ Deceased (*Age:* ____)	

Does anyone else in your family have any of the following medical conditions? If *Yes*, please explain.

□ Cancer: _____

_____

□ Thyroid problems: _____

_____

□ Diabetes: _____

_____

□ Early heart disease: _____

_____

□ Rheumatologic disease (Lupus, Rheumatoid arthritis, etc.): _____

_____

□ Other: _____

_____

_____

Is there anything else you would like to inform the doctor of?

_____

_____

_____