

Patient Information Form

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Beeper/Cellular: _____

Birthdate: _____ Age: _____ Sex: M F

email address: _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

Social Security: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Insurance Information:

Primary Insurance: Insured's Name _____

Relationship to Insured: ___Self ___Spouse ___Child ___Other

Member ID# _____ Group # _____

Insurance Company Name: _____ P.O. Box _____

City _____ State _____ Zip Code _____ - _____

Insurance Verification Telephone # _____

Patient History Profile

Patient Name: _____

Date: _____

Do you have now or had in the past?

Circle Any Yes Responses

	Last Episode		Last Episode
Bleeding Disorder	_____	Fast Heart Beat	_____
Anemia	_____	Chest Pains	_____
Weakness	_____	Blood Clots	_____
Fatigue	_____	High Blood Pressure	_____
Weight Loss	_____	Heart Attack/Disease	_____
Weight Gain	_____	Varicose Veins	_____
Cancer/Tumor	_____	Gout	_____
Chills	_____	Urination at Night	_____
Fever	_____	Trouble Swallowing	_____
Headaches	_____	Nausea	_____
Head Trauma	_____	Vomiting	_____
Dizziness	_____	Diarrhea	_____
Tremor	_____	Abdominal Pain	_____
Seizures	_____	Constipation	_____
Paralysis	_____	Blood In Stool	_____
Fainting Spells	_____	Yellow Skin/Eyes	_____
Blurred Vision	_____	Hepatitis/Liver Disease	_____
Blindness	_____	Appendicitis	_____
Glaucoma	_____	Peptic Ulcer	_____
Deafness	_____	Gall Bladder Disease	_____
Ringing in the Ears	_____	Excessive Drinking of Fluids	_____
Pain in the Ears	_____	Excessive Urination	_____
Runny Nose	_____	Excessive Bruising	_____
Sinus Trouble	_____	Diabetes	_____
Persistent Hoarseness	_____	Thyroid Disease	_____
Nose Bleeds	_____	Dislocation	_____
Persistent Sore Throat	_____	Sprains	_____
Voice Changes	_____	Arthritis	_____
Breast Pain	_____	Muscle Pain	_____
Breast Lumps	_____	Night Cramps	_____
Discharge from Nipples	_____	Itching of Skin	_____
Shortness of Breath	_____	Skin Rash	_____
Asthma	_____	STD	_____
Pneumonia	_____	Painful Urination	_____
Bronchitis	_____	Blood in Urine	_____
Cough	_____	Bladder Infection	_____
Smoke Cigarettes	_____	Kidney Stones	_____
Smoke Cigars	_____	Menstrual Cramps	_____
Smoke Pipes	_____	Tuberculosis	_____
Cough up Blood	_____	Pain in Calf When Walking	_____

Patient History (cont.)

Patient Name: _____

Date: _____

Education History:

Circle Highest Level Obtained

Elementary High School/Technical School 2 yr. College 4 yr. College Graduate School

Social History:

Circle Yes Responses

	Last Use	How Long	How Much
Alcohol	_____	_____	_____
Tobacco	_____	_____	_____
Drugs	_____	_____	_____

Sexual History:

Circle Yes Responses

Sexually Active Abstinent Heterosexual Homosexual Bisexual Multiple Partners

Condom Use Contraception

Last Sexual Contact _____

Menstrual/Obstetric History:

Age of Onset: _____

Duration: _____

Amount: _____

Last Normal Menstrual Period: _____

No. of Pregnancies: _____

No. of Abortions: _____

No. of Miscarriages: _____

Complications of Pregnancy: _____

Family History:

Circle Yes Responses

Hypertension Diabetes Stroke Cancer Tuberculosis Deafness Gout/Arthritis Kidney Disease Migraine
Bleeding Disorder Glaucoma Obesity Heart Disease High Cholesterol Other

	Age(s)	Health	Age of Death	Present Illness(es) or Cause of Death_____
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Aunt	_____	_____	_____	_____
Uncle	_____	_____	_____	_____
Children	_____	_____	_____	_____

Patient History (cont.)

Medical History:

Circle Yes Responses

Childhood Illnesses

Mumps Measles Chicken Pox Rheumatic Fever Rubella Polio Other

Immunizations (date)

Tetanus _____
Pnuemovax _____
Influenza _____
Mumps _____
Measles _____
Rubella _____

Current Medications:

Drug: _____ Dose: _____ Last Taken: _____
Drug: _____ Dose: _____ Last Taken: _____
Drug: _____ Dose: _____ Last Taken: _____
Drug: _____ Dose: _____ Last Taken: _____
Drug: _____ Dose: _____ Last Taken: _____

Allergies:

Hospitalizations:

Date	Reason	Opearation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last T.B. Skin Test _____ Results _____

HIV Status _____positive _____negative _____unknown