

Patient Information Form

Name _____ Appointment Date _____
Date of Birth ____/____/____
Month / Day / Year

1) Chief Complaint:

1. _____
2. _____
3. _____
4. _____

2) Social History:

Marital Status: _____
Children & Ages: _____
Type of work: _____
Smoking History: _____
Alcohol Intake: _____
Exercise: _____
Diet: _____

3) Past Major Illness(es) and Dates:

1. _____
2. _____
3. _____
4. _____
5. _____

4) Past Surgeries and Date:

1. _____
2. _____
3. _____
4. _____
5. _____

5) Family History of Medical Problems:

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

6) Allergies to Medication:

1. _____
2. _____

7) Medications You Are Currently Taking (Strength and Directions):

1. _____
2. _____
3. _____
4. _____
5. _____

8) Review of Systems—Check Those That Apply

General:

Fever _____
Fatigue _____
Sweats _____
Chills _____
Change in Weight _____

Cardiovascular:

Chest pain _____
Palpitations _____
High BP _____

Neurological:

Dizziness _____
Tremors _____
Seizures _____
Weakness _____

Eyes:

Change in Vision _____
Vision Loss _____
Cataracts _____
Glaucoma _____

Respiratory:

Shortness of breath _____
Cough _____
Wheezing _____

Psychiatric:

Depression _____
Anxiety _____
Memory Loss _____

Ears, Nose & Throat:

Hearing Impairment _____
Ringing in Ears _____
Hoarseness _____
Voice Changes _____
Nose Bleeds _____
Sinus Infections _____

Gastrointestinal:

Nausea _____
Vomiting _____
Diarrhea _____
Constipation _____

Endocrine:

Cold Intolerance _____
Heat Intolerance _____
Excessive Thirst _____

Skin:

Rashes _____
Itching _____
Dry Skin _____
Sores _____

Misc:

Allergies _____
Abnormal Bruising _____
Enlarged Lymph Nodes _____

Genitourinary:

Frequent Urination _____
Kidney Stones _____
Prostate Swelling _____
Abnormal Menses _____

Name _____

Diabetic Patients Complete The Following

Diagnosed as diabetic: _____ Last Eye Exam: date _____

Urine micro-albumin: date: _____

Previous Hgb A1C: date: _____ value: _____%

Type of Meter _____

Frequency of Blood Sugar testing _____

Blood Sugar ranges _____

Insulin Pump Type: _____

Date Insulin Pump started: _____

Basal Rates: _____

Insulin: Carb Ratio: _____

Correction Sliding Scale: _____

Patients with Bone Loss (Osteoporosis/Osteopenia)

Last Bone Density _____

History of Fractures _____ Date _____

Tallest Height _____

Calcium Intake _____