

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 \_\_\_\_\_