## PATIENT INFORMATION SHEET

NAME: ALLERGIES:	GEND	ER: DO	DOB:		3:
DO YOU HAVE A LIVING	G WILL: YES	NO			
List ALL MEDICATIONS you		counter (OTC) medications an	d vitamins. Includ	e specific de	ses and
when taken. If you don't know, plo	ase call your pharmacist to	confirm.			
PERSONAL MEDICAL HISTO	DRY: (Please circle all t	hat apply)			
ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthr	ritis	
Alcoholism	Dementia	HIV	Seizure Disorder		
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea		
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke		
Anxiety	Diverticulitis	Lupus	Thyroid Disorder		
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis		
Arthritis	GERD (Acid Reflux)	Macular Degeneration	Last Menstrual	Date:	Normal
Asthma	Glaucoma	Neuropathy	Period Colonoscopy	Yes/No	Abnormal Normal
Bipolar	Heart Disease	Osteopenia/Osteoporosis		Date:	Abnormal
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	Mammogram	Yes/No Date:	Normal Abnormal
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	Dexa (Bone Density)	Yes/No Date:	Normal Abnormal
Cancer:	High Blood Pressure	Peptic Ulcer	Pap	Yes/No	Normal
Headaches	Kidney Stones	Psoriasis		Date:	Abnormal
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)			
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Other medical problems not list	ed above:		( )		
Surgical History: Please list all p	rior surgeries and approxi	mate dates performed.			
SOCIAL / CULTURAL HIS	TORY:				
Education Level:   Elementary	4 17	ocational 🗆 College 🗖	Graduate / Profession	al	
Education Level Elementary	E High Soulon E Vo	Conogo =			
Are there any vision problems that	at affect your communicat	ion? □Yes □No			
Are there any hearing problems the	nat affect your communica	ation?			
Are there any limitations to under	standing or following inst	ructions (either written or verbal)	)? □Yes □ N	lo	
Current Living Situation (Check a	ll that apply):				
☐ Single Family ☐	Multi-generational			Other:	-
Household	Household	Fa	cility		

Alcohol:   Current   Past   Never   Drinks/week:   Recreational Drug Use:   Current   Past   Never   Type:   Are you sexually active?   Yes   No  Are there any personal problems or concerns at home, work, or school you would like to discuss?   Yes   No  Are there any cultural or religious concerns you have related to our delivery of care?   Yes   No  Are there any financial issues that directly impact your ability to manage your health?   Yes   No  How often do you get the social and emotional support you need?   Never  Comments (Please feel free to comment on any answers marked "yes" above):  FAMILY HISTORY:  FATHER: Living: Age Deceased: Age  Alcoholism	Are you sexually active?	o Use: 🗆 Current	] Past □ Never	Туре:	Amount/day:	Number of Years:	
Are there any personal problems or concerns at home, work, or school you would like to discuss?	Are you sexually active?	rrent 🗀 Past 🗆 Neve	r Drinks/wee	k:			
Are there any personal problems or concerns at home, work, or school you would like to discuss?	Are there any personal problems or concerns at home, work, or school you would like to discuss?	g Use: 🗆 Current 🗆	Past   Never	Туре:			
Are there any cultural or religious concerns you have related to our delivery of care?   Yes   No  Are there any financial issues that directly impact your ability to manage your health?   Yes   No  How often do you get the social and emotional support you need?   Never    Always	Are there any cultural or religious concerns you have related to our delivery of care?	active?	No				
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How often do you get the social and emotional support you need?    Always	How often do you get the social and emotional support you need?    Always	tural or religious conc	erns you have rel	ated to our delivery of car	re? □Yes □ No		
Alcoholism Bipolar Disorder Depression High Cholesterol Stroke Arthritis Dementia Bipolar Disorder Depression High Cholesterol High Cholesterol Stroke  MOTHER: Living: Age Deceased: Age Migraines  Alcoholism Bipolar Disorder Depression High Cholesterol Stroke  Stroke Stroke  Thyroid Disorder  Deceased: Age Migraines  Other:  MOTHER: Living: Age Deceased: Age Migraines  Deceased: Age Migraines  Alcoholism Bipolar Disorder Depression High Cholesterol Migraines  Other:  MOTHER: Living: Age Deceased: Age Migraines  Alcoholism Bipolar Disorder Depression High Cholesterol Osteoporosis Anemia Cancer: Diabetes 1 or 2 High Blood Pressure Stroke  Asthma COPD/Emphysema DVT (Blood Clot) Kidney Disease Thyroid Disorder  Asthma COPD/Emphysema DVT (Blood Clot) Kidney Disease Thyroid Disorder  Arthritis Dementia Heart Disease Migraines	Alcoholism	ancial issues that direc	tly impact your a	bility to manage your hea	lth? □Yes □ No		
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Arthritis Dementia Heart Disease Migraines	Arthritis Dementia Heart Disease Migraines  Other:		nhysema				
	Other:		рпувена		-	Thyroid Disorder	
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NW NGC	SIBLINGS:						
		al providers you see (	n a regular bas	is (i.e. Cardiologist, Ment	al Health Provider, Kidne	ey Doctor, Dentist, etc.)	
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BIBLINGS:			g Use:	GORY:  Bipolar Disorder Cancer: COPD/Emphysema Dementia  Bipolar Disorder Cancer: COPD/Emphysema Dementia  Bipolar Disorder Cancer: COPD/Emphysema Dementia	g Use:	g Use:   Current   Past   Never Type:	