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PATIENT MEDICAL INFORMATION SHEET

Name: _____ Age: _____ Date: _____

Who referred you to this office? _____ phone#: _____

Who is your primary care physician (PCP)?

Your pharmacy _____ Phone # _____

Why are you seeing the doctor today?

Do you have Allergies to Drugs: (CIRCLE) None Penicillin Sulfa IVP Dye (please list others)

Do you have other Allergies to: (CIRCLE and list) Latex

other

:

List All Current Medications with doses frequency: None

List All Herbs and Supplements that you take with doses and frequency?

For your primary complaint:

Location (Identify specific location of the pain or problem)

Quality (Has the pain increased or decreased since the injury or symptom happened)

Severity (Identify on a scale of 1 to 10 the degree of pain)

None - 1 2 3 4 5 6 7 8 9 10 - Severe

Duration (Identify the length of time of the injury or symptom)

Timing (Is there a time or condition that increases or decreases the pain)

Context (How did the injury happen or when did the symptoms start)

Modifying Factors (Do certain conditions increase or decrease the pain or problem)

Associated Signs & Symptoms (Has this injury or symptom created problems with other areas of the body)

List All Operations/ Surgeries: None

List All of Your Medical Conditions & onset date: None

High Blood Pressure Diabetes Heart Attack Stroke Heart Murmur Congestive Heart Failure

Other Heart Problems _____

Asthma COPD/Emphysema Pneumonia HIV(AIDS) Impotence Kidney Stones or Infection

Rheumatic Fever Thyroid Trouble Tuberculosis Ulcer Seizures Head Injury

Cancer of: _____

Others: _____

Any of These Run in Your Family? (Please circle and follow with relationship to you.)

High Blood Pressure Diabetes Kidney Stones Stroke

Bleeding Heart Disease Problems with anesthesia

Cancers (type) _____

Do you smoke? No If you ever smoked, when did you quit? _____

Yes How many packs per day? ½ 1 2 3 For how many years? _____

Do you drink alcohol? No Yes How much? _____

Do you drink caffeinated beverages? No Yes How much?

Drug use? No Yes How much?

Describe exercise routine: type and frequency

Hobbies: _____

Spiritual/meditative practices? Describe type and frequency.

Community involvement/volunteering? _____

Are you: Married Single Divorced Widowed

Do you have Children? No Yes How many

What is Your Occupation?

Have you had Blood transfusions? Yes No When?

Year of last physical Where?

When did you have your last chest X-ray? Electrocardiogram? Pap Smear? Colonoscopy?

List all Imaging studies since diagnosis? CT, MRI, PET scans, Ultra sounds, Bone scans, etc.

Pathology results? From biopsies or surgical specimens.

List treatments modalities? Chemotherapy (which drugs), radiation, immunotherapy, other

FOR WOMEN ONLY

Are you Pregnant? Yes No

Number of pregnancies?

Age of first pregnancy?

Last menstrual period?

Duration of menses?

Painful menses?

Regular menses?

Miscarriages/terminations? How many?

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS: NONE

General/Constitutional:	Fever	Weight Loss	Chills
Eyes, Ears, Nose, Throat:	Blurry Vision	Cataracts	Hearing Loss
Cardiovascular/Respiratory:	Shortness of Breath	Swollen Ankles	chest pains
Genitourinary:	Incontinence	Painful Urination	Blood in Urine
Musculoskeletal/Neurologic:	Chronic Back Pain	Chronic Neck Pain	Numbness
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusions