

DATE _____

PATIENTS INFORMATION FORM

THE FOLLOWING INFORMATION WILL BE KEPT IN STRICTEST CONFIDENCE

LAST NAME	FIRST	MIDDLE
BIRTHDATE	AGE	GENDER <div style="display: flex; justify-content: space-between;"> MALE FEMALE </div>

ALLERGIES

PLEASE LIST ANY DRUG ALLERGIES AND THE TYPE OF REACTION YOU EXPERIENCE WITH EACH DRUG

DRUG	REACTION

CHIEF COMPLAINT _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

PLEASE CHECK HERE IF THE ANSWER TO ALL CONDITIONS LISTED BELOW IS "NO" []

YES	NO	CONDITION	YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR
<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL/DRUG PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	HEMORRHOIDS
<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA/LOW BLOOD COUNTS	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	HERNIA
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD CLOTS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH CHOLESTEROL
<input type="checkbox"/>	<input type="checkbox"/>	CANCER (TYPE _____)	<input type="checkbox"/>	<input type="checkbox"/>	INFERTILITY (Difficulty getting Pregnant)
<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	CIRCULATION PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	LIVER
<input type="checkbox"/>	<input type="checkbox"/>	COPD/EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	DISEASE/JAUNDICE/HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES (SUGAR)	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION/ANXIETY
<input type="checkbox"/>	<input type="checkbox"/>	EASY BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	EATING DISORDER (ANOREXIA/BULEMIA)	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER
<input type="checkbox"/>	<input type="checkbox"/>	ECZEMA	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES/EPILEPSY
<input type="checkbox"/>	<input type="checkbox"/>	GENITAL HERPES	<input type="checkbox"/>	<input type="checkbox"/>	SERIOUS INJURY/ ACCIDENT
<input type="checkbox"/>	<input type="checkbox"/>	GENITAL INFECTIONS (CHLAMYDIA/GONORRHEA)	<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL ANEMIA
<input type="checkbox"/>	<input type="checkbox"/>	GENITAL WARTS/HPV	<input type="checkbox"/>	<input type="checkbox"/>	SKIN DISORDER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	GOUT	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEM
<input type="checkbox"/>	<input type="checkbox"/>	HAY FEVER/ POLLEN ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	TRANSFUSION (YR _____)
<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS (TB)
<input type="checkbox"/>	<input type="checkbox"/>	HEARING LOSS	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK/HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (SPECIFY _____)
<input type="checkbox"/>	<input type="checkbox"/>	LOSS OF SEXUAL FUNCTION	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (SPECIFY _____)
<input type="checkbox"/>	<input type="checkbox"/>	DISCHARGE FROM PENIS	<input type="checkbox"/>	<input type="checkbox"/>	PROSTATE TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	LUMP IN TESTICLES	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING BETWEEN PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	SURGERY ON PRIVATE PARTS
<input type="checkbox"/>	<input type="checkbox"/>	HEAVY PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL PAP SMEAR
<input type="checkbox"/>	<input type="checkbox"/>	EXTREME MENSTRAL PAIN	<input type="checkbox"/>	<input type="checkbox"/>	BREAST DISCHARGE
<input type="checkbox"/>	<input type="checkbox"/>	UNUSUAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMP
<input type="checkbox"/>	<input type="checkbox"/>	HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	PAINFUL INTERCOURSE

SURGERY/HOSPITALIZATION/ACCIDENT/INJURY HISTORY

PLEASE LIST ANY SURGERIES/ HOSPITALIZATION/ ACCIDENTS /INJURIES AND THE YEAR

OPERATION/CONDITION REQUIRING HOSPITALIZATION/ ACCIDENT/INJURY	YEAR

MENSTRUAL HISTORY	OBSTETRIC HISTORY
DATE OF LAST MENSTRUAL CYCLE: _____	NUMBER OF TIMES YOU'VE BEEN PREGNANT: _____
AGE AT FIRST PERIOD: _____	NUMBER OF CHILDREN BORN ALIVE: _____
LENGTH OF PERIODS: _____	NUMBER OF CHILDREN BORN DEAD: _____
NUMBER OF DAYS BETWEEN PERIODS: _____	NUMBER OF MISCARRAIGES: _____
AGE WHEN PERIODS STOPPED: _____	NUMBER OF CAESAREAN SECTIONS: _____
	COMPLICATIONS OF PREGNANCY: _____
DATE OF LAST PAP: _____	DATE OF LAST MAMMOGRAM: _____
NORMAL _____ ABNORMAL _____	NORMAL _____ ABNORMAL _____

IF YOU ARE SEXUALLY ACTIVE, DO YOU USE BIRTH CONTROL: YES _____ NO _____ N/A _____ TYPE _____

PERSONAL HABITS

DO YOU REGULARLY DRINK ALCOHOL	YES	NO	IF YES, WHAT AMOUNT? _____
DO YOU DRINK > 4 CUPS OF CAFFEINATED BEVERAGES PER DAY?	YES	NO	IF YES, WHAT AMOUNT? _____
DO YOU SMOKE?	YES	NO	IF YES, HOW MANY PACKS PER DAY? _____
ARE YOU A FORMER SMOKER?	YES	NO	IF YES, HOW MANY YEARS? _____
HAVE YOU EVER USED STREET DRUGS?	YES	NO	IF YES, WHAT TYPE? _____
ARE YOU CURRENTLY USING STREET DRUGS?	YES	NO	IF YES, WHAT TYPE? _____

FAMILY HISTORY

RELATIVE	AGE	IF DECEASED, AGE AT DEATH	MEDICAL PROBLEMS/ CAUSE OF DEATH
MOTHER			
FATHER			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			
SIBLINGS			
CHILDREN			

DATE OF LAST TETNUS BOOSTER: _____ DATE OF LAST PNEUMONIA VACCINE: _____