PATIENT INFORMATION SHEET

DATE: _____/_____/ 2017

LAST NAME: FIRST NAME:

STREET ADDRESS:

CITY: STATE: ZIP:

PRIMARY PHONE: CELL PHONE: TEXTS: Y OR N

SEX: M / F / T DATE OF BIRTH: / / EMAIL:

Social Security #

RACE: ETHNICITY:

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOW(ER) DOMESTIC PARTNER

PRIMARY CARE PHYSICIAN: REFERRING PHYSICIAN:

How did you hear about us?

MEDICAL HISTORY

What is your main reason for seeing us today?

When is the last time you took an antihistamine?

What is the name and location of your pharmacy?

Current Medications:

Name of drug	Dosage	How often taken?

Are you allergic to any medications? YES / NO (If yes, please list medications and reactions.)

FAMILY MEDICAL HISTORY

Has a family member (living or deceased) been diagnosed with any of the following?

	Y / N	Family Member		Y / N	Family Member
Anaphylaxis			Food Allergies		
Angioedema			High Blood Pressure		
Asthma			Immunodeficiency		
Cancer			Lupus		
Ezcema			Other Allergies		
Diabetes			Thyroid Disease		

SURGICAL HISTORY

List any surgeries below:

Surgery	Approximate Date

PERSONAL MEDICAL HISTORY

Have you ever had any of the following?

	Y / N		Y / N		Y / N
Chest Pain		Asthma		Shortness of breath	
Hypertension		Dizziness/Fainting		TB/Lung disorder	
Heart attack		Cancer		Ulcers	
Stroke		Diabetes		Skin disorders	
Chronic Headache		Arthritis		Hepatitis	
Glaucoma		Difficulty hearing		Cataracts	
Allergies		Memory loss		Digestive problems	
Eczema		Hemorrhoids		Frequent urinary infections	
Depression		Kidney Disease		Blood in stool	
Seizures		Movement Disorder		Tics (motor or verbal)	
Other Neurological Disorders		High Cholesterol		High triglycerides	

SOCIAL HISTORY

Are you a smoker? Y / N If so, how many packs a day to you smoke? _____

Is there a smoker in your home? Y / N

Do you have passive smoke exposure? Y / N

Please circle your type of residence: Home Apartment Condominium

How long have you lived in your current residence? _____

Approximately how old is your home? _____

Do you have carpeting in your home? Y / N

Are you exposed to animals? Y / N

Do you have pets? Y / N If so, what kind? _____

CIRCLE ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING:

Allergy/Immunology

Blistering of skin	Congestion	Cough	Hives	Itching	Rash
Sneezing	Wheezing	Unusual reaction to medication(s), food, animals, or insects			

General/Constitutional

Change in appetite	Fever	Chills	Fatigue	Headache	Lightheadedness
Weight gain/loss					

Ophthalmologic

Discharge of the eye(s)	Dry eye(s)	Itching of the eye(s)	Pain in the eye(s)	Red eye(s)	

ENT

Decreased hearing	Decreased sense of smell	Difficulty swallowing	Dry mouth	Ear pain	Masses/Growths
Nosebleeds	Ringing in the ears	Sinus pain	Sore throat	Swollen glands	

Endocrine

Acne	Cold intolerance	Difficulty sleeping	Dizziness	Excessing sweating	Excessing thirst
Frequent urination	Hair loss	Heat intolerance	Hot flashes	Irregular menses	

Respiratory

Chest pain	Coughing blood	Pain with inspiration	Sputum production	Shortness of breath at rest or exertion	

Cardiovascular

Cyanosis	Palpitations	Dizziness	Dyspnea on exertion	Fluid in legs	Irregular heartbeat

Gastrointestina

Abdominal pain	Decreased appetite	Diarrhea	Nausea	Difficulty swallowing	Heartburn
Vomiting					

Musculoskeletal

Joint stiffness	Leg cramps	Muscle aches	Painful joints	Swollen joints	Weakness

Dermatologic

Acne	Discoloration	Dry skin	Eczema	Hair changes	Sun sensitivity
Rash	Skin cancer	Skin oozing	Scaly lesions of skin/scalp		

Neurologic

Dizziness	Headache	Pain	Seizures		

Psychiatric

Anxiety	Depressed mood	Difficulty sleeping	Stressors	Substance abuse	

CANCELLATIONS/NO-SHOWS

If you are unable to keep an appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. **If you do not cancel your appointment within 24 hours of your scheduled appointment a $50.00 fee will be charged to your patient account balance.**

A "no-show" is someone who misses an appointment without canceling within 24 hours of their scheduled appointment time. Failure to present at the time of the schedule appointment will be recorded in the patient's record as a "no-show" and a $50.00 fee will be charged to your patient account balance.

When three (3) "no-show" appointments have been documented you will receive a letter from the physician discharging you from the practice.

We will offer 30 days of emergent care only and transfer your records when you find a new physician.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PATIENT REPRESENTATIVE SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____