

Patient Information Sheet

Name: _____ Date: _____

Age: _____ DOB: ____ / ____ / ____ Referred by _____

Sex _____ Marital Status: _____ PCP: _____

If under 18, Parent or legal guardian's name: _____

Are you right or left handed? R L Occupation: _____

Date of injury: ____ / ____ / ____ Employer: _____

Sports, hobbies, other jobs: _____

Current work status: _____ Last date worked: _____

Chief Complaint and brief history: _____

Have you consulted another doctor about this condition? Yes No

Whom? _____ Date: ____ / ____ / ____

If hospitalized, name of facility: _____

Personal Medical History

General status of health Excellent Good Fair Poor

Height: _____ Weight _____ Is your weight stable? Yes No

If you have had any of the following, please check all that apply:

- | | | |
|---|---|---|
| Asthma <input type="checkbox"/> | Raynaud's disease <input type="checkbox"/> | Malignancies <input type="checkbox"/> |
| Emphysema <input type="checkbox"/> | Diabetes <input type="checkbox"/> I <input type="checkbox"/> II | Neurological problems <input type="checkbox"/> |
| Shortness of breath <input type="checkbox"/> | Other hormone disorder <input type="checkbox"/> | Congenital problems <input type="checkbox"/> |
| Chest pain or pressure <input type="checkbox"/> | Frequent heartburn <input type="checkbox"/> | Hereditary disorders <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Hiatus hernia <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Heart attack <input type="checkbox"/> | Stomach upset from meds <input type="checkbox"/> | Psychiatric illness <input type="checkbox"/> |
| Irregular heart beats <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Reaction to anesthesia <input type="checkbox"/> |
| High blood pressure <input type="checkbox"/> | Other liver disease <input type="checkbox"/> | Eating disorder <input type="checkbox"/> |
| Thyroid disorder <input type="checkbox"/> | Bleeding problems <input type="checkbox"/> | Cigarette smoking <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Kidney disease <input type="checkbox"/> | Frequent alcohol use <input type="checkbox"/> |
| CREST, Scleroderma <input type="checkbox"/> | Any other serious illness: <input type="checkbox"/> _____ | |

Are you allergic to penicillin? Yes No Reaction: _____

List other drug allergies: _____

Family and Social History

Indicate acute and chronic family illnesses: _____

Health Problems: _____

MOTHER Alive Deceased FATHER Alive Deceased SIBLINGS Alive Deceased

LIVING SITUATION: Alone With others FUNCTIONAL STATUS: Independent Need assistance

What is your approximate daily consumption of the following?

Coffee/tea _____ Alcohol _____ Tobacco _____

Other intoxicating drugs _____

Please List All Medicines and Dietary Supplements

NAME OF MEDICATION	DOSAGE /FREQUENCY	YEARS TAKEN	PRESCRIBED BY

Previous Surgeries, Illnesses, Injuries

TYPE OF SURGERY	DOCTOR	HOSPITAL	APPROXIMATE DATE

ILLNESS OR INJURY	DOCTOR	HOSPITAL	APPROXIMATE DATE

Is there anything else regarding your health that we should know when treating you?

The above is accurate to the best of my knowledge.

Sign: _____ Date: _____