PATIENT INFORMATION FORM

Welcome to our office and thank you for completing this form.

Patient Information

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Age: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone (_____) _____

Email: _____ Cell Phone (_____) _____

❑ Single ❑ Married ❑ Full-Time Student ❑ Part-Time Student

Employer's Name: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone (_____) _____

Referred By: _____

Spouse or Significant other information:

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Age: _____ Sex: _____

Employer's Name: _____ Occupation: _____

Other Information

Nearest relative or friend (not living with you) _____ Relationship: _____

City: _____ State: _____ Zip: _____ Phone (_____) _____

Pharmacy Information:

Name of your Pharmacy: _____

Address (major cross streets) of Pharmacy: _____

Phone Number of Pharmacy:_____

PATIENT HEALTH HISTORY FORM

Information contained here will be treated in a confidential manner and not released without your authorization. Please take the time to answer all appropriate questions to the best of your knowledge, as this information is important to your doctor in his decisions regarding your care.

Date: _____ Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Ideal Weight: _____ Sex: _____ Marital Status: _____

Referred By: _____ Personal Physicians: _____

Employment: _____

MEDICATIONS	Yes	No		Yes	No		Yes	No
Pain Medication	❑	❑	Cortisone/Steroids	❑	❑	Antibiotics	❑	❑
Blood Thinners	❑	❑	Weight Loss Pills	❑	❑	Birth Control Pills	❑	❑

List all names of meds (with amounts and how often) taken: _____

MEDICATION ALLERGIES / SENSITIVITIES	Yes	No		Yes	No		Yes	No
Penicillin	❑	❑	Other Antibiotics	❑	❑	Other	❑	❑
Sulfa Drugs	❑	❑	Aspirin	❑	❑			

List reactions which have occurred for each above "Yes" response: _____

SURGICAL HISTORY

List all previous operations, dates and any complications:

Date	Age	Operation	Physician/Hospital	Complications

Are you pregnant? ❑ Yes ❑ No How many pregnancies have you had? ____ Did you breast feed? ❑ Yes ❑ No

Date/Result Last Mammogram: _____

MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems/Anemia	❑	❑	High Blood Pressure	❑	❑	Eye Problems	❑	❑
Anesthesia Problems	❑	❑	Herpes/Cold Sores	❑	❑	Heart Attack/Disease	❑	❑
Scarring Problems	❑	❑	Breast Disease	❑	❑	Other	❑	❑
Diabetes	❑	❑						

Explain and give dates for each of the above "Yes" responses: _____

Do you use alcohol? ❑ No ❑ Yes ❑ Light ❑ Heavy

Do you Smoke: ❑ Yes ❑ No Avg. # packs a day: _____ # of years _____ Date Quit: _____

FAMILY HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems	❑	❑	High Fever from Surgery	❑	❑	Other Cancer	❑	❑
Anesthesia Problems	❑	❑	Breast Cancer	❑	❑			

List family members and explanation if necessary for each above "Yes" response: _____

Patient Signature: _____ Physician Signature: _____