PATIENT INFORMATION SHEET

DATE: ____________________

NAME: ____
FIRST MIDDLE LAST

DATE OF BIRTH:__________________AGE:____________SSN:________________________________ ______

ADDRESS:____

CITY, STATE & ZIP:____

HOME PHONE WITH AREA CODE:_____________________ **CELL** WITH AREA CODE______________________

EMPLOYMENT:________________________________OCCUPATION:_____________________________

EMPLOYMENT PHONE NUMBER:____

PRIMARY INSURANCE:____

POLICY HOLDER NAME:____________________________ DATE OF BIRTH:________________ ____________

POLICY HOLDER SOCIAL SECURITY #____

SECONDARY INSURANCE:____

POLICY HOLDER NAME:____________________________ DATE OF BIRTH:_____________________________

POLICY HOLDER SOCIAL SECURITY #____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:______________________________________

WHO MAY WE TALK TO ABOUT YOUR MEDICAL CARE?___________________________________

MAY WE LEAVE A MESSAGE ON YOUR HOME VOICEMAIL? Y N CELL PHONE? Y N
WITH OTHER RESIDENTS? Y N

WHO IS YOUR PRIMARY CARE PHYSICIAN?____

____
ADDRESS PHONE FAX

WHO REFERRED YOU TO OUR OFFICE?____

____
ADDRESS PHONE FAX

OTHER PHYSICIANS/HEALTHCARE ENTITIES INVOLVED WITH MY MEDICAL CARE :

____
PROVIDER PHONE FAX

____
ADDRESS

AGE:_____

MEDICAL HISTORY – PLEASE LIST YOUR MEDICAL CONDITIONS:

____
____
____
____

SURGERIES & DATES:____
____
____

ALLERGIES:____

SOCIAL HISTORY:

OCCUPATION:____

MARITAL STATUS – M S D W SPOUSES OCCUPATION_________________________________

CHILDREN______ AGES:___________

ALCOHOL:___________________TOBACCO_________________ILLICIT DRUGS_____________________

FAMILY HISTORY OF:

OSTEOPOROSIS Y N WHO:____________RHEUMATOID ARTHRITIS Y N WHO:__________________

GOUT Y N WHO:____________________OTHER CONNECTIVE TISSUE DISEASE Y N WHO__________

MOTHER LIVING Y N Medical Conditions: ____

FATHER LIVING Y N Medical Conditions: ____

MEDICATION SHEET

Name of Medication	Dosage	How Often Taken	Months/years taken

Review Of Systems (Please circle Yes if you have recently experienced a symptom)

General

Fatigue	Yes	No
Weight Loss	Yes	No
Night Sweats	Yes	No
Fevers	Yes	No
Sensitivity in Cold	Yes	No
Blood Clots Legs/Lungs	Yes	No

Skin

Skin Rash	Yes	No
Hair Loss/Thinning	Yes	No
Nail Changes	Yes	No
Reaction to Sun	Yes	No
Psoriasis	Yes	No
Tightening of Skin	Yes	No
Color changes to Fingers	Yes	No

Eyes

Vision Changes	Yes	No
Eye Pain	Yes	No
Red Eyes	Yes	No
Dry Eyes	Yes	No

Ears

Loss of Hearing	Yes	No
Ringing in Ears	Yes	No

Nose

Frequent Nosebleeds	Yes	No
Persistent Congestion	Yes	No

Mouth

Mouth sores	Yes	No
Pain with Chewing	Yes	No
Dry Mouth	Yes	No

Cardio/Respiratory

Cough	Yes	No
Pain with Breathing	Yes	No
Shortness of Breath	Yes	No
Heart Murmur	Yes	No
Chest Pain	Yes	No

GI

Loss of Appetite	Yes	No
Difficulty swallowing	Yes	No
Heartburn	Yes	No
Nausea or Vomiting	Yes	No
Diarrhea	Yes	No
Stomach Ulcer	Yes	No
Constipation	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No

Nervous System

Chronic Headache	Yes	No
Memory Loss	Yes	No
Seizures	Yes	No
Numbness/Tingling	Yes	No
Weakness/Paralysis	Yes	No

OB/Gyn

Number of Pregnancies___________

Number Miscarriages_____________

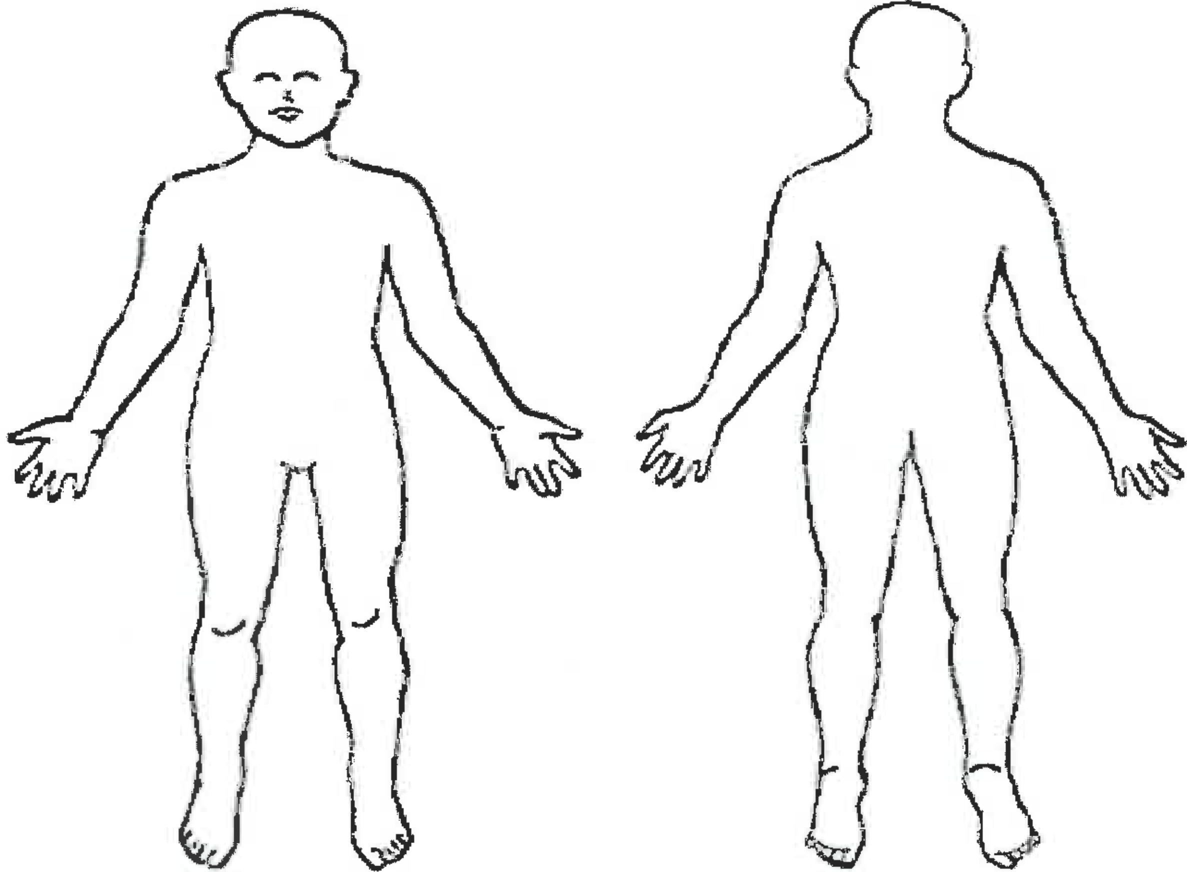
Hysterectomy	Yes	No
Hormone Replacement	Yes	No

Osteoporosis

Kidney Stones	Yes	No
Height Loss	Yes	No
Used Prednisone	Yes	No
Had Fractures	Yes	No
Food Intolerance	Yes	No

I have personally reviewed the above with the patient_________________________________

Please put an X over areas of Pain



Your Most Significant area of Pain is 1)________________________________

2)________________________________

3)________________________________

Do you notice Swelling of your Joints? Y N Which____________________

The Pain is Worst at Which Time of Day AM Mid-Day PM

Do you have Morning Stiffness Y N How Long ________________

What Increases the Pain ____

What Improves the Pain ____

Medications I have tried for the Pain______________________________________

Have you been in Physical Therapy_______________ When ____________________

Have you tried Acupuncture Y N Have you tried Massage Therapy Y N