PATIENT INFORMATION SHEET

Name: ____Birthdate: ______________________

Address: _____________________________________ City:__________________________ Zip: ____________

Home Phone Number: _______________________________ Cell Number: ______________________________

Social Security#: ____________________________

Marital Status: ____________ Name of Spouse/Parent____

Emergency contact: _______________________________________Relationship to patient:________________

Emergency contact telephone number:____

Employer: _________________________________ Work Phone Number: ______________________________

Family Physician: _____________________________________ Date last seen: __________________________

How did you learn about the practice? ____

Medical History
Please circle the following conditions that pertain to your health:

Diabetes	High Blood Pressure	High Cholesterol
Heart Attack(s)	Congestive Heart Failure	Atrial Fibrillation
Thyroid Disorder	Circulation Problems	Cancer (type________________________)
Stroke	Seizures	Tremors
Emphysema	Asthma	Phlebitis/Bloodclots
Stomach ulcers	Anxiety/Depression	Other _____________________________

Have you recently experienced any of the following? Please circle any that apply:
Fever Chills Nausea Vomiting Weakness Fatigue

Please list all your medications or provide a list that we can copy:

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Please list any drug allergies: ____

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