Patient Medical Information Sheet

Name ____ **Birth date** _________ **Age** _____

Reason for Visit ____ **Date** __________

Allergies to Medications ____

Current Medications ____

(name and dose) ____

Over the counter meds ____

Other doctors you currently see ____

Your Past Medical History (all information is kept strictly confidential)

Surgeries (dates) ____

Hospitalizations ____

Women

First day of last period _______________ **Birth Control?** _______________

Last Pap smear ________ **Number of pregnancies** ______ **No. of children** ______

Last Mammogram _______ ☐ **Family History of Breast cancer** _______________

Men

Last prostate exam _______ ☐ **Family History of Prostate cancer** _______________

HIV & Hepatitis risks

Blood transfusion ☐ Y ☐ N **IV drug use** ☐ Y ☐ N **Homosexual relations** ☐ Y ☐ N
Needle sticks ☐ Y ☐ N **Work with bodily fluids** ☐ Y ☐ N **Tattoos, body piercing** ☐ Y ☐ N
Sex with more than 10 people, or people with known AIDS, Hepatitis B or C ☐ Y ☐ N

Immunizations: check each disease and date of last immunization ☐ Hepatitis B ______ ☐ Hepatitis A ____
☐ Pneumonia ______ ☐ Tetanus (every 10 years) ______ ☐ Influenza ______ ☐ MMR ______

Do YOU have a history of the following:

☐ Diabetes ☐ High blood pressure ☐ High Cholesterol ☐ Heart disease/ attack
☐ Cancer ☐ Epilepsy / seizures ☐ Pneumonia / Asthma ☐ Sinus infections
☐ Hepatitis ☐ Migraine headaches ☐ Thyroid (high / low) ☐ Depression

Risks of melanoma or skin cancer: ☐ Family history of skin cancer (melanoma) ☐ Bad sunburns under age of 18
☐ More than 3 dark moles ☐ Moles that are irregular, change color or bleed

Details: ____

Smoking ☐ Yes ☐ No _____ packs per day **Tried to quit?** ☐ Yes ☐ No ___________

Alcohol use ☐ Yes ☐ No _____ drinks per week **What do you drink?** _______________

Drug use ☐ Yes ☐ No ___________________ **Diet** **Food allergies:** _________________

FAMILY Medical History

☐ Cancer ☐ Diabetes ☐ Heart disease ☐ High blood pressure
☐ Depression ☐ Stroke ☐ High cholesterol ☐ Asthma / Emphysema

Details: ____

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Signed ______________________________ **Physician review** __________