PATIENT INFORMATION SHEET

NAME: GENDER: DOB:

ALLERGIES:

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

PERSONAL MEDICAL HISTORY:

________ Last Menstrual Period	______ Date: __________	Normal Abnormal
Colonoscopy Prostate exam ________	Yes/No Date:____ ______	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal

Pap /mammogram	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

Social/Cultural History

Education Level: □ Elementary □ High School □ Vocational □ College □ Graduate / Professional □Yes □ No Are there any vision problems that affect your communication? Are there any hearing problems that affect your communication? Are there any limitations to understanding or following instructions (either written or verbal)? □Yes Current Living Situation (Check all that apply):

□ Single Family □ Multi-generational □ Homeless Household

□ Shelter

□ Skilled Nursing Facility

Smoking/ Tobacco Use: □ Current □ Past □ Never Type: _________________ Amount/day: ___________ Number of Years: ________ Alcohol: □ Current □ Past □ Never Drinks/week: ___________ Recreational Drug Use: □ Current □ Past □ Never Type: ____ Are you sexually active? □Yes □ No

FAMILY HISTORY:

FATHER:

MOTHER:

SIBLINGS:

____

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List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Patient signature____

Date: ________________________________