



PATIENT INFORMATION SHEET

Date: _____

Legal Name (Last, First) _____ Preferred Name _____

Address (street, city, state, zip): _____/_____/_____/_____

Primary Phone Number: _____

Date of Birth: _____

E-mail Address: _____

SS#: _____

Primary insurance: _____

Are you the subscriber? Yes No

If no, relationship to subscriber: _____

Subscriber's DOB: _____

Subscriber's full name: _____

Subscriber's sex: M F T

Preferred Pharmacy (Name, address, & phone number): _____

Family Physician: _____ Referring Physician: _____
(First name, Last name, Phone #) (First name, Last name, Phone #)

Do we have permission to speak with this person if necessary regarding your medical consultation? Yes No

Employer name: _____

Marital Status: _____

Race (circle one): American Indian / Asian / African American / Caucasian / Hispanic / Other: _____

Preferred Language (circle one): English / Indian / Spanish / Russian / Other: _____

Emergency Contact Information:

Name	Relationship	Phone Number

Reason for today's visit: _____ Date of onset: _____

Please list all **medications** you are now taking and their **dosages** (including birth control pills, diuretics (water pills), blood pressure medications, tranquilizers, hormones, blood thinners, aspirin, bufferin, "recreational drugs", etc.)

Medication	Dosage	Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you have an Advance Directive? (living will) Yes No

Next side

Any medical problems? Yes No If so, please list: _____

Female patients: Are you currently pregnant or breastfeeding? Yes No

Are you allergic to any medications? Yes No If yes, which one(s)? _____

If yes, please describe your allergy or reaction: _____

Previous Surgery (please list)

Date (Mo/Year) Operation Hospital City Surgeon Anesthesia (Local/General)

Check this box if you have not had any previous surgeries

Previous Hospitalizations (other than for surgery)

Date (Mo/Year) Reason

Check this box if you have not had any previous hospitalizations

Family History:

	Year of Birth	Living	Dead	Cause of Death	Major Diseases/Conditions
Father					
Mother					
Sister(s)					
Brother(s)					
Daughter(s)					
Son(s)					

Social History:

Current smoker Number of cigarettes smoked per day: 5 or less 6-10 11-20 21-30 31 or more
 Former smoker
 Non-smoker

Alcohol Consumption in Past Year:

Never Monthly or less 2-4 times/month 2-3 times/week 4 or more times/week

Typical Amount of Drinks per Occasion:

1-2 3-4 5-6 7-9 10 or more N/A

Height: _____ Weight: _____

Immunizations: Flu shot: yes/no, Approx Date: _____ / Pneumonia Yes/No, Approx Date: _____

FOR OFFICE USE ONLY:

SCD INP