

**PATIENT INFORMATION SHEET**

**Name** \_\_\_\_\_ **Sex:** F M **DOB** \_\_\_\_\_ **Age** \_\_\_\_\_ **Date** \_\_\_\_\_

**Marital Status:** Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Number of Children \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Since Year:** \_\_\_\_\_

**Race: (Please Circle)** American Indian/Alaska Native Asian African American Caucasian Pacific Islander Declined Other

**Physician: (Please Circle)** Dr. Smith Dr. Rybnicek Lavonia Womack, NP Megan Stephens, NP Pam Burr, NP

**Primary Care Physician** \_\_\_\_\_ **Referred By** \_\_\_\_\_

It is important for our Physicians/ NPs to have your complete health history. Please help us by taking the time to provide this information accurately and completely. This information will be a confidential part of your medical record.

**PAST SURGICAL AND MEDICAL HISTORY-Check ALL that apply**

MEDICAL HISTORY	X	Onset, Comments	SURGICAL HISTORY	X	Date, Comments
Anorexia / Bulimia			Colon		
Arthritis / Joint Swelling			Stomach		
Asthma			Heart:		
Bleeding Disorder			Stent / Bypass		
Blood or Infectious Disease			Valve		
Cancer, Type:			Pacemaker		
Colon Polyps			Defibrillator		
Crohn's Disease			Joint Replacement		
Diabetes, Type 1 or 2			Gallbladder		
Epilepsy / Seizures			Hysterectomy		
Anxiety			Appendix		
Depression			Prostate		
Gallstones			Bladder		
Glaucoma			C-Section		
Headaches / Fainting / Dizziness			Abortion		
Heart Problems / Chest Pain			Breast		
High Cholesterol			Other Surgeries: (Please List)		
Liver Disorders					
Hiatal Hernia / GERD					
High / Low Blood Pressure					
Kidney Disease					
Lung Disease					
Sleep Apnea / CPAP			Anesthesia Problems		
Stomach Disorders / Ulcers			Previous EGD		
Stroke			Previous Colonoscopy		
Thyroid Problems					
Tuberculosis			Hepatitis A		
Ulcerative Colitis			Hepatitis B		
Menopause (Age)			Hepatitis C		

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SOCIAL HISTORY:**

Alcohol	Past	Current	Never	Duration & Amount
Coffee / Caffeine	Past	Current	Never	Duration & Amount
Substance Abuse	Past	Current	Never	Duration & Amount
Tobacco	Past	Current	Never	Duration & Amount
Blood Transfusions	Yes	No	When?	
Tattoos	Yes	No		
Do you exercise?	Yes	No	How much?	

**FAMILY HISTORY:** Please indicate any **RELATIVES** with the following diseases.

Alcoholism	Yes	No	
Cirrhosis / Jaundice	Yes	No	
Colon Cancer	Yes	No	
Colon or rectal polyps	Yes	No	
Crohn's/Ulcerative Colitis	Yes	No	
Diabetes	Yes	No	
Gallstones	Yes	No	
Hemachromatosis	Yes	No	
Heart disease	Yes	No	
High Blood Pressure	Yes	No	
Liver Disease	Yes	No	

**SYMPTOM REVIEW** Check (☒) symptoms you currently have or have had in the past

<p><b>General:</b></p> <input type="checkbox"/> Weight Loss _____ lbs <input type="checkbox"/> Weight Gain _____ lbs <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <p><b>Eyes:</b></p> <input type="checkbox"/> Changes in Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataract <p><b>HENT:</b></p> <input type="checkbox"/> Headache <input type="checkbox"/> Injury (Head) <input type="checkbox"/> Dizziness <input type="checkbox"/> Deaf or Uses Hearing Aid <input type="checkbox"/> Cold <input type="checkbox"/> Dentures <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat <p><b>Breast:</b></p> <input type="checkbox"/> Lumps <input type="checkbox"/> Discharge	<p><b>Cardiac:</b></p> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Breath <p><b>Respiratory:</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Emphysema <input type="checkbox"/> Snoring <input type="checkbox"/> Uses CPAP/ Sleep Apnea <p><b>Gastrointestinal:</b></p> <input type="checkbox"/> Ulcers <input type="checkbox"/> Jaundice <input type="checkbox"/> Polyps <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Heartburn <input type="checkbox"/> Reflux	<input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Hernia <p><b>Genitourinary:</b></p> <input type="checkbox"/> Urgency <input type="checkbox"/> Hesitancy <input type="checkbox"/> Frequency <input type="checkbox"/> Infections <input type="checkbox"/> Stones <input type="checkbox"/> Hernia <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Menstrual Irregularity <p><b>Skin:</b></p> <input type="checkbox"/> Rash <input type="checkbox"/> Lumps <input type="checkbox"/> Itching <input type="checkbox"/> Hair Change/Loss	<p><b>Neurologic:</b></p> <input type="checkbox"/> Tingling/Numbness <input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Fainting/Blackouts <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <p><b>Musculoskeletal:</b></p> <input type="checkbox"/> Joint Pain/Stiffness <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteoarthritis <p><b>Psychiatric:</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Nervous Breakdown
--	--	---	---

**Other Physicians Who Are Actively Treating You:**

Pain Clinic:  
 Doctor:  
 Doctor:

Condition:  
 Condition:  
 Condition:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_