

Patient Information Form		Patient Name:		Date: (mm/dd/yyyy)	
		Birth Date: (mm/dd/yyyy)		Sex: M F	
Please list any allergies or intolerances to drugs or other substances:					
Please list the names of your medicines, their dosages, strengths, and how many times per day you take them:					
Family Medical History: Please list the ages of your family and any major illnesses they had.					
AGES	Mother:	Father:	Sister(s):	Brother(s):	Children:
MAJOR ILLNESSES	Mother:		Father:		
	Sister(s):		Brother(s):		Children:
Have any of the following medical conditioned occurred in your family? (check boxes)					
tuberculosis	diabetes mellitus	high blood pressure	kidney disease		
emphysema	li ver disease	epilepsy	neurological disorder		
heart disease	anemia	hemophilia	thyroid disease		
colon cancer	breast cancer	ovarian cancer	prostate cancer		
osteoporosis					
Doctor Notes:					
Personal Information:					
Occupation:		Highest Level of Schooling: High School College/Trade School Post-Graduate			
Marital Status: Single Married Divorced Widowed Other					
Do you smoke? Yes No		If yes, how much do you smoke?			
If you are a former smoker, how long ago did you quit? mm/dd/yyyy)			Do you use smokeless tobacco? Yes No		
How much caffiene do you have each day? 2 or less 3 to 5 6 or more					
How often do you drink alcohol? Never or Rareley 0-3 times per week Nearly every day					
How much do you usually drink when you have alcohol? 2 or less 3 to 5 6 or more					
Do you have alcoholism or think you might? Yes No					
Have you had a problem with substance abuse? Yes No					
Sexual Orientation: Not Sexually Active Heterosexual Homosexual / Bisexual Other					
Are you on a special diet?					
How much do you exercise?					
Do you have pets? Yes No					
Doctor Notes:					