



### Patient Information Sheet

Today's Date: \_\_\_\_\_

Last:	First:	Middle:
Address:		Email:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security Number:
Ethnicity:	Language Preference:	Race:

**Advanced Directives: Please mark if you have any of the following (Please bring copies to first appointment)**

<input type="checkbox"/> Healthcare Power of Attorney Name: _____	<input type="checkbox"/> Living Will
<input type="checkbox"/> DNR Form (Do Not Resuscitate)	<input type="checkbox"/> Financial Power of Attorney

**Primary caregiver information:**

Name:	Relationship:
Address:	Email:
City:	State:                  Zip:
Home Phone:	Cell Phone:

**Billing Address:**

<input type="checkbox"/> Same as patient	<input type="checkbox"/> Same as Primary caregiver	
<input type="checkbox"/> Other:		
<b>Pharmacy (and Location) and Phone #:</b>		
<b>Primary Care Physician's Name:</b>		
Address:		
City:	State:	Zip Code:
Doctor's Phone Number:		Fax:
<b>Names of Other Physician's Seen:</b>		

**Health Insurance**

<b>Primary Insurance Company</b>		
Insured's Name and DOB		Insured's Soc. Sec. #
Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Policy #	Group #	

<b>Secondary Insurance Company</b>		
Insured's Name and DOB		Insured's Soc. Sec. #
Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Policy #	Group #	

Have you had a scan of your brain (CT or MRI)?  Y  N  
 If yes, date and location where it was performed. \_\_\_\_\_

Primary reason for your visit today:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:**

Relative	Living?	Age	Illness/Cause of Death
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Father	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N		
Children	<input type="checkbox"/> Y <input type="checkbox"/> N		
Children	<input type="checkbox"/> Y <input type="checkbox"/> N		

**Is there any history of:**

Dementia:  Y  N  
 Alzheimer's:  Y  N  
 Memory Problem:  Y  N  
 Parkinson's:  Y  N

**If so, who?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Is there a history of abuse?**

Verbal  Y  N  
 Sexual  Y  N  
 Physical  Y  N

**Patient's Hospitalizations/Surgeries:**

Date	Hospital	Type of Surgery/Reason for Hospitalization

**Patient's Medical History: *Please check all that apply***

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Head Trauma    |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV            |
| <input type="checkbox"/> Parkinson's            | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Lyme's disease |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Seizure             | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Loss of Consciousness  | <input type="checkbox"/> Concussion          |   |
| <input type="checkbox"/> Other, describe: _____ |  |   |

**Allergies:**  No known allergies

Allergens	Reaction

**Social History:**

Marital status:  Married  Single  Widowed  Divorced

# of prior marriages \_\_\_\_\_

Spouse's name: \_\_\_\_\_

Spouse's health: \_\_\_\_\_

Do you have children?  Y  N How Many? \_\_\_\_\_

Are you or your spouse a veteran?  Y  N

List highest grade completed in school: \_\_\_\_\_

What is your current or former occupation? \_\_\_\_\_

Native language: \_\_\_\_\_ Others spoken: \_\_\_\_\_

Right or  Left handed

Do you currently smoke?  Y  N  
 If yes, How long have you been smoking? \_\_\_\_\_  
 How many packs a day do you smoke? \_\_\_\_\_

Did you quit smoking?  Y  N  
 If yes, When did you quit? \_\_\_\_\_  
 How many years did you smoke prior to quitting? \_\_\_\_\_  
 How many packs a day did you smoke? \_\_\_\_\_

Do you drink alcohol?  Y  N  
 If yes, What type, and how much per day? \_\_\_\_\_

Have you used alcohol in the past? \_\_\_\_\_  
 If yes, What type, and how much per day? \_\_\_\_\_

Did you ever use illicit drugs?  Y  N

Do you exercise regularly?  Y  N

Did you get a flu shot this year?  Y  N

**Current Medications:** Please bring all your prescription and non-prescription medications with you to this appointment **IN THE ORIGINAL BOTTLES**. Include eye drops, pills, nasal sprays, ointments, laxatives, herbals, supplements, vitamins, etc. Separate those that you use regularly from those that you only use as needed. List all medications you use regularly:

Medication Name	Dose/Strength	How Many? How many times per day?