Patient Information Form **DATE:**_____ **Name:**_____

Please list any conditions or chronic illnesses you have (Such as high blood pressure, diabetes, pregnancy, glaucoma, prostate problems, etc.)

_____
_____
_____

☐ **None**

What **major surgeries** have you had and the dates of the surgery and the doctor performing surgery (if known)

_____
_____
_____

☐ **None**

Please list all the **medicines** being taken that were **prescribed by a doctor or dentist** (Include what you take for chronic conditions, birth control, etc.)

_____
_____
_____
_____

☐ **None**

Please list **medicines** you sometimes take that were bought **without a prescription**. (Such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins, etc.)

_____
_____
_____
_____

☐ **None**

PLEASE LIST ALLERGIES TO MEDICINES

_____
_____
_____

☐ **None**

Please list all individuals that live with you and their age

_____
_____
_____
_____

Family History of**:**

	YES	NO	(Family Member)
Breast Cancer -	☐	☐	
Colon Cancer **-**	☐	☐	
Prostate Cancer -	☐	☐	
Heart Disease -	☐	☐	
Diabetes-	☐	☐	
Hypertension**-**	☐	☐	

☐ **None**

Do you smoke?

☐ **Yes** ☐ **No** ☐ **Used To ***

If yes, how much? _____

***If used to**, how much? _____

How long did you smoke? _____

When did you quit? _____

Do you drink alcoholic beverages?

☐ **Often** ☐ **Sometimes** ☐ **No**

How many drinks a week?_____

Any history of drug abuse?

☐ **Yes** ☐ **No**

Do you exercise?

☐ **Yes** ☐ **No**

If yes, how many times per week? _____

Do you drink caffeinated drinks?

☐ **Yes** ☐ **No**

If yes, how many drinks per week?_____

Are you sexually active?

☐ **Yes** ☐ **No**

Submit