PATIENT INFORMATION SHEET

903.284.6105
2114 East Rusk St.
Jacksonville TX 75766

Name _____ DOB: _____ Date: _____

Allergies: _____

Social History:

Recreational Drug Use: Current Past Never

Smoking: Currently Past Never Packs/day:_____

Alcohol: Currently Past Never Drinks/day: _____

List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins

What pharmacy do you use/prefer? _____

PERSONAL MEDICAL HISTORY: (please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder problems/Incontinence
Bleeding problems
Cancer:_____
Carpal Tunnel
Headaches
Crohn's Disease
COPD
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (blood clot)
Eczema
Emphysema
Gallstones
GERD (acid reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Kidney Stones
Kidney Disease
Lupus
Liver Disease
Macular Degeneragtion
Migraines
Nosebleeds
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Sciatica
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period: yes / no date: _____ Normal / Abnormal
Colonoscopy: yes / no date: _____ Normal / Abnormal
Mammogram: yes / no date: _____ Normal / Abnormal
Dxa (Bone Density): yes / no date: _____ Normal / Abnormal

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age:_____

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other: _____

MOTHER: Living: Age_____ Deceased: Age:_____

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other: _____

Siblings: _____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____

_____

Patient signature: _____ Date: _____