PADDER HEALTH SERVICES

PATIENT INFORMATION SHEET

NAME: ______________________ GENDER: ____________ DOB: __________ DATE: ___________

ALLERGIES: ____

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.

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

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: _______________
- ☐ Headaches
- ☐ Crohn's Disease
- ☐ COPD/ Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: 1 or 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot)
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Attack (MI)
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Peptic Ulcer
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis

Last Menstrual Period	Date: _________	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

____

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

____________________________________ ____________________________________

____________________________________ ____________________________________

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _________________

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: ________________ Amount/day: __________ Number of Years: _______

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: __________

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: ____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

____

____

FAMILY HISTORY:

FATHER: Living: Age _____________ Deceased: Age _____________

Alcoholism
Anemia
Asthma
Arthritis
Bipolar Disorder
Cancer: ______________
COPD/Emphysema
Dementia
Depression
Diabetes 1 or 2
DVT (Blood Clot)
Heart Disease
High Cholesterol
High Blood Pressure
Kidney Disease
Migraines
Osteoporosis
Stroke
Thyroid Disorder

Other: ____

MOTHER: Living: Age _____________ Deceased: Age _____________

Alcoholism
Anemia
Asthma
Arthritis
Bipolar Disorder
Cancer: ______________
COPD/Emphysema
Dementia
Depression
Diabetes 1 or 2
DVT (Blood Clot)
Heart Disease
High Cholesterol
High Blood Pressure
Kidney Disease
Migraines
Osteoporosis
Stroke
Thyroid Disorder

Other: ____

SIBLINGS:

____

____

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

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