EAGLE CREEK **FAMILY MEDICINE**

*Treating the **whole person** through **focused** individual care*

PATIENT INFORMATION SHEET

NAME:____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:_______________

Crohn's Disease

COPD/Emphysema

Dementia

Depression

Diabetes: 1 or 2

Diverticulitis

DVT (Blood Clot)

GERD (Acid Reflux)

Glaucoma

Headaches

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 ☐ Assisted/Skilled Nursing Facility ☐ Other: ____________________

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type:__________ # per day:__________ # 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: Birth year:__________ ☐ Alive ☐ Deceased age ________

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

Other:____________________

MOTHER: Birth year:__________ ☐ Alive ☐ Deceased age ________

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

Other:____________________

SIBLINGS: Number:______ Health Problems: ____________________

____

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

____

Patient Signature:____________________Date: ____________