Patient Information Form

Name: Age: Gender: Date of Appointment:

Patient Information

Patient's First Name Middle Name Last Name

Sex Date of Birth Social Security Number Referred by

Patient's Address City State Zip

Home Phone Mobile Phone Email

Pharmacy Pharmacy Phone Pharmacy Address

Primary/Emergency Contact
Name
Address
Phone

Relationship
Email

Secondary Contact
Name
Address
Phone

Relationship
Email

Patient School information

School Name School Phone

Billing and Insurance

Primary Health Insurance

Insurance Company Plan

Plan Number Group Number Insured's Employer/School

Insured's Name
(as it appears on insurance card or ID)

Relation to Patient Insured's Phone

Insured Social Security Number Insured's Birthdate

Secondary Health Insurance

Insurance Company Plan

Plan Number Group Number Insured's Employer/School

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Insured's Name
(as it appears on insurance card or ID)
Relation to Patient
Insured's Phone

Insured Social Security Number
Insured's Birthdate

Responsible Party

Same as

Billing Name
Phone
Relation to Patient

Address
City
State
Zip

Past Medical History

Has the patient ever had any of the following?

ADHD/ADD	Diabetes	Pneumonia
Allergies	Ear Infections	Seizures
Asthma	Eczema	Strep Throat
Autism Spectrum	Frequent Colds	Tonsillitis
Chicken Pox	Heart Murmur	Other:

Hospitalizations & Surgeries

Reason
Date

Reason
Date

Medications

What medications is the patient currently taking? (Include vitamins, minerals, supplements)

Name
Dosage
Frequency

Name
Dosage
Frequency

Name
Dosage
Frequency

Name
Dosage
Frequency

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Allergies

Is the patient allergic to any of the following?

Medical:

Adhesive Tape	Iodine (including contrast dye)	Seizure Medicines
Anesthetics	Latex	Sulfa
Aspirin	Penicillin	
Codeine	NSAIDs (ibuprofen, Naprosyn, Advil)	

Food and Environment Allergies:

Bee Stings	Eggs	Tree Pollen
Cats	Grass Pollen	Weed Pollen
Dogs	Nuts	Wheat
Dairy	Shellfish	Other insect stings
Dust	Soy	

Details / Reactions:

Family Health Habits

How often does the patient use a seatbelt or carseat?

Does the patient ride a bicycle, ski, or ride horses?

If yes, how often does he/she use a helmet?

Is the patient exposed to second hand smoke?

Does anyone in the household have a drinking or drug problem?
(including prescription drug abuse)

How many cans of soda and caffeinated drinks like coffee or Red Bull does the patient consume each day?

How much physical activity does the patient get each week?

Child’s current grade level at school:

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Any failed grades?

Problems in school?

If yes, problems are:

Family Medical History

Has anyone in the patient's family (mother, father, siblings, grandparents, cousins) been diagnosed or treated for:

	Relative
Allergies	
Blindness	
Cancer	
Deafness/Hearing Problem	
Diabetes	
Heart Problems	
Hepatitis B or C	
High Blood Pressure	
HIV/AIDS	
Learning Problem	
Mental Illness (depression, anxiety)	
Migraines	
Obesity	
Rheumatologic Disease	
Seizures	
Tuberculosis	
Other:	

Review of Symptoms

Does the patient have any of the following:

Acne	Constipation	Frequent Urination	Nightmares
Anemia	Cough	Hair Loss	Nose Bleeds
Anxiety	Depression	Hearing Loss	Sleep Problems
Bed Wetting	Diarrhea	High Fever	Stomach Aches

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Bleeding Gums	Dizziness	Hives	Suicide Attempts
Bleeding Tendency	Easy Bruising	Jaundice	Vision Problems
Bloody Urine	Eczema	Joint Pains	Unusual Fears
Body/Breath Odor	Excessive Crying	Low Appetite	Vomiting Spells
Burning Urine	Fatigue	Nervous	Wheezing
Chronic Rash	Frequent Colds	Night Sweats	

Diet

Please describe the patient's typical daily diet:

Immunizations

Please check and date all immunizations the patient has had:

	Month & Year		Month & Year
Chicken Pox		Meningitis	
Diptheria		MMR (Measles, Mumps, Rubella)	
Hepatitis A		Pneumonia	
Hepatitis B (series of 3)		Polio	
HPV Vaccine		Tetanus	
Influenza (Flu Shot)			

For Teenagers to Complete

Are you sexually active?

Type of contraception:

Have you ever been pregnant or caused a pregnancy?

Do o smoke cigarettes?

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Do you drink alcohol?

Do you use recreational drugs?
(including abuse of prescription drugs)

For girls, age when you got your first period: