PATIENT INFORMATION SHEET

*(**Non**-Partners patients complete other side as well)*

To help us better evaluate your condition, please complete the following form. If you have any questions we will be glad to help you. Thank you.

Name:_____Date of Birth: _____ Occupation:_____

Gender at Birth: _____ Age: _____ Marital Status _____ Height _____ Weight _____ Work Status:_____

Allergies _____

Date of Injury/Onset: _____/_____/_____ Are you **RIGHT** or **LEFT** handed? (circle appropriate option)

Chief complaint and brief history of present illness/injury:_____

_____

_____

What are your hobbies/activities that you enjoy? _____

Past Medical History: (Please circle all new symptoms since last visit to Primary Care Physician)

Weight loss
Weigh gain
Fever or chills
Weakness
Fatigue

Rashes
Lumps
Itching
Hair and nail changes
Headache
History of concussion
Decreased hearing
Ringing in ears
Earache

Use of glasses or contacts
Vision loss
Blurry or double vision
Glaucoma
Cataracts

Taking an anticoagulant such as
Warfarin, Coumadin, Xarelto
Cold intolerance
Sweating

Sore throat
Hoarseness
Swollen glands
Lumps
Stiffness

Cough
Coughing up blood
Shortness of breath
Wheezing
Sleep apnea

Chest pain or discomfort
Tightness
Palpitations
Difficulty breathing
History of heart attack, date ____
Pacemaker

Swallowing difficulties
Heart burn
Nausea
Rectal bleeding
Change in appetite
Nervousness
Stress

Constipation
Diarrhea
Urinary frequency
Urgency
Burning
Blood in urine

Leg cramping
Calf pain with walking
Back pain
Swelling of joints

Dizziness
Fainting
Seizures
Depression
Memory loss
Tremors
History of stroke, date: _____

Nosebleeds
Ease of bruising
Ease of bleeding
Known coagulation disorder

_____

_____

Other _____

Completed By _____ Date _____

Please List All Medicines and Dietary Supplements

NAME OF MEDICATION	DOSAGE/FREQUENCY	YEARS TAKEN	PRESCRIBED BY

Previous Surgeries, Illnesses, Injuries

TYPE OF SURGERY	DOCTOR	HOSPITAL	APPROXIMATE DATE

ILLNESS OR INJURY	DOCTOR	HOSPITAL	APPROXIMATE DATE

Is there anything else regarding your health that we should know when treating you?