# PATIENT INFORMATION SHEET

**Please fill this form out before you arrive at the office and bring it with you when you come for your appointment.**

**Date:**_____ **Chief Complaint:**_____

**Name: First**_____ **MI**____ **Maiden**_____**Last:**_____

**Address:**_____

**City:**_____**State**_____ **Zip Code**_____

**Date of Birth** _____**m/** _____**d/** _____**y** **Age:**_____

**Sex:** ☐ **Male** ☐ **Female**

**Social Security Number**_____ **Phone (Home)**_____

**Marital Status:** ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced**

**County of Birth:**_____**Race:**_____

**Have you ever been a patient at Cleveland Regional Medical Center:**_____

**Have you ever been a patient at Kings Mountain Hospital:**_____

**Employer:**_____**Employer Phone #**_____

**Occupation:**_____ **Education:**_____

**Responsible Party:**_____

**Responsible Party Employer:**_____

**Insurance No 1:**_____ **Insurance Number:**_____

**Name of Insured:**_____**Insured Date of Birth**_____

**Insurance No 2:**_____ **Insurance Number:**_____

**Name of Insured:**_____ **Insured Date of Birth**_____

**Medicare Number:**_____ **Medicaid No.**_____

**Referring Physician:**_____

**Other Physicians:**_____

**PERSONAL MEDICAL HISTORY: CIRCLE**

| | | | |
|---|---|---|---|
| High Blood Pressure | Diabetes | High Cholesterol | Migraines |
| Epilepsy | Glaucoma | Stroke | Asthma |
| Emphysema | COPD | Pneumonia | Tuberculosis |
| Skin Disease | Heart Attack | Angina | Heart Failure |
| Rheumatic Fever | Arthritis | Gout | Heart Valve Problem |
| Diverticulitis | Jaundice | Liver Disease | Anemia |
| Arrhythmia | Kidney Disease | Kidney Stones | Irritable Bowel |
| Urinary Infection | Syphilis | Gonorrhea | Chlamydia |
| HIV/AIDS | Psoriasis | Thyroid Problem | Adrenal Problem |
| Osteoporosis | Fibromyalgia | Hepatitis | Melanoma |
| Vascular Problems | Varicose Veins | Sleep Apnea | Renal Failure |

Cancer_____ Mental Illness _____

## OPERATIONS: LIST TYPE AND APPROXIMATE YEAR

| Surgery | Year | Surgery | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| FAMILY HISTORY | LIST ALL DISORDERS (DIABETES, CANCER, STROKE, HEART ATTACK, ETC) |
|---|---|
| Father | |
| Mother | |
| Spouse | |
| Brothers | |
| Sisters | |
| Children | |

**SOCIAL HISTORY**

**With whom do you live?**_____

**If you required assistance after surgery who would be able to stay with you?**_____

**For what periods of time? (circle) all the time evenings only days only few hours**

**Do you use tobacco? Y/N Type and daily amount**_____**How long?**_____

**Tobacco use in past Y/N Type and daily amount**_____ **How long?**_____

**Alcoholic beverages? Y/N Type and daily amount**_____ **How long?**_____

**Type**_____ **Weekly amount**_____ **How long?**_____

**Recreational drugs? Y/N In the past? Y/N Type and route administered**_____

**PATIENT NAME:** _____

## REVIEW OF SYSTEMS: *(Please check only if frequent or bothersome)*

| | | | |
|---|---|---|---|
| **General:** | Fatigue | Weight Gain/Obesity | |
| | Fever | Weight Loss | |
| | Sweats | Intolerance Heat/Cold | |
| **EYES:** | Blurry Vision | Eye Pain | |
| | Double Vision | Loss of Vision | |
| **ENT:** | Nosebleeds | Nasal Stuffiness | Hearing Loss |
| | Sore Tongue or Mouth | Hoarseness | Ringing in Ears |
| **HEART:** | Palpitations | Irregular Heartbeat | Fainting |
| | Swollen Feet | Short of Breath with Walking | |
| | Chest Pain/Tightness | Pain in Back of Leg when Walking | |
| | Leg Swelling | Pressure in Front/Back of Chest | |
| **LUNGS:** | Cough | Short of Breath | Short of Breath with walking |
| | Coughing up Sputum | Snoring | Difficulty Breathing |
| | Wheezing | Coughing up Blood | |
| **ABDOMEN:** | Abdominal Pain | Blood in Stool | Constipation |
| | Diarrhea | Heartburn | Difficulty Swallowing |
| | Frequent Laxative | Vomiting Blood | Hemorrhoids |
| | Nausea | Reflux | Vomiting |
| **KIDNEYS:** | Blood in Urine | Urinate at Night | Problems with Genitals |
| | Urinary Hesitancy | Loss of Control | Flank Pain |
| | Hernia | Impotence | Testicle Mass |
| | Testicle Pain | Frequent Urination | Difficulty Urinating |
| **WOMEN: ONLY** | Breast Mass | Heavy Periods | Nipple Discharge/Bleeding |
| | Post Menopausal | Breast Pain | Menopausal Symptoms |
| | Periods Irregular | Pregnant | Vaginal Discharge |
| **MUSCLE/ SKELETON** | Back Pain | Bone Fracture | Joint Pain |
| | Joint Swelling | Muscle Weakness | Pain in Feet/Legs |
| | Stiffness | Swelling | |
| **SKIN:** | Itching | Rashes | Non-Healing Sores |
| | Bruising | Growths | Changing Moles/Warts |
| | Discolorations | | |
| **NEURO:** | Seizure | Memory Loss | Loss of Strength |
| | Dizziness | Tremor | Lose Ability to Speak |
| | Incoordination | Tingling | Numbness |
| | Headaches | Falls | |
| **PSYCH:** | Disoriented | Hallucination | Suicidal |
| | Anxiety | Memory Loss | Memory Acuity |
| | Depression | | |