

**PATIENT INFORMATION RECORD**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring MD: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Social History: Occupation \_\_\_\_\_

Cigarette Use \_\_\_\_\_ Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_ Drugs \_\_\_\_\_

**PAST MEDICAL HISTORY:** (Circle if you have been diagnosed with the condition.)

- |                     |                   |                  |            |
|---------------------|-------------------|------------------|------------|
| High Blood Pressure | Diabetes          | COPD             | Ulcers     |
| Heart Attack        | Liver Problems    | TB               | Reflux     |
| Stroke              | Hepatitis         | Asthma           | Cancer     |
| Heart Disease       | Kidney Problems   | Seizures         | HIV / AIDS |
| Heart Failure       | Bleeding Problems | Thyroid Problems | Depression |

**HOSPITALIZATIONS / SURGERIES:**

REASON	DATE	LOCATION	DETAILS

**ALLERGIES:** (Please list all allergies including medications, foods, latex, etc...)

**CURRENT MEDICATIONS:** (Including alternative medications / vitamins / supplements / herbs)

NAME	DOSE	FREQUENCY	NOTES

BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ WT \_\_\_\_\_

HPI \_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Nurse Signature \_\_\_\_\_