SALTZER MEDICAL GROUP

PATIENT INFORMATION SHEET

Please bring all medication bottles with you to your appointment

Patient Name: _____ DOB: _____ Date Completed: _____

Allergies: _____

Do you have or have you been treated for any of the following:

Arthritis	☐Yes	☐No	Irregular Heart Beat	☐Yes	☐No	Acid reflux	☐Yes	☐No
Asthma	☐Yes	☐No	Heart attack	☐Yes	☐No	Ulcers	☐Yes	☐No
COPD/Emphysema	☐Yes	☐No	*Year:*_____			Hepatitis	☐Yes	☐No
Sleep Apnea	☐Yes	☐No	Stroke	☐Yes	☐No	Seizures	☐Yes	☐No
Diabetes	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Mental Health	☐Yes	☐No
Thyroid	☐Yes	☐No	Blood clots	☐Yes	☐No	Teeth/Gum Disease	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Bleeding disorder	☐Yes	☐No			

Other Medical Conditions: _____

Surgical History (list all prior surgeries and approximate dates):

_____

How many visits to the Emergency Room (ER) have you had in the past 12 months?

☐ 0 ☐ 1-2 ☐ 3+

How many overnight stays at the hospital have you had in the past 12 months?

☐ 0 ☐ 1-2 ☐ 3+

Last Menstrual Period	Date:	Provider:
Pap Smear	Date:	Provider:
Colonoscopy	Year:	Provider:
Mammogram	Date:	Provider:
Dexa/Bone Density	Date:	Provider:
Flu Vaccine	Date:	
Pneumonia Vaccine (Pneumovax 23 or Prevnar 13)	Date:	
Tdap/Tetanus/Pertussis Vaccines	Date:	

SOCIAL/CULTURAL HISTORY

What is the highest level of school you have finished?

☐ Education Level: Less than high school ☐ Some college, no degree

☐ High school degree or equivalent ☐ College degree or beyond

Do you live alone? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No ☐ N/A ☐ Patient declined to answer

Do you use recreational drugs? ☐ Yes ☐ No ☐ N/A ☐ Patient declined to answer

Do you use tobacco product and are you interested in quitting?

☐ Yes ☐ No ☐ N/A ☐ Patient declined to answer

FAMILY HISTORY

Father: Living: ☐ Deceased: ☐ **Mother:** Living: ☐ Deceased: ☐

Siblings: Living: ☐ Deceased: ☐ **Children:** Living: ☐ Deceased: ☐

Alcoholism:	☐ Father	☐ Mother	☐ Siblings	Heart Disease:	☐ Father	☐ Mother	☐ Siblings
Anemia:	☐ Father	☐ Mother	☐ Siblings	High Cholesterol:	☐ Father	☐ Mother	☐ Siblings
Asthma:	☐ Father	☐ Mother	☐ Siblings	Kidney Disease:	☐ Father	☐ Mother	☐ Siblings
Arthritis:	☐ Father	☐ Mother	☐ Siblings	Migraines:	☐ Father	☐ Mother	☐ Siblings
Mental Health:	☐ Father	☐ Mother	☐ Siblings	Osteoporosis:	☐ Father	☐ Mother	☐ Siblings
Cancer:	☐ Father: _____	☐ Mother: _____	☐ Siblings: _____				
COPD/Emphysema:	☐ Father	☐ Mother	☐ Siblings	High Blood Pressure	☐ Father	☐ Mother	☐ Siblings
Dementia:	☐ Father	☐ Mother	☐ Siblings	Stroke:	☐ Father	☐ Mother	☐ Siblings
Diabetes:	☐ Father	☐ Mother	☐ Siblings	Thyroid Disease:	☐ Father	☐ Mother	☐ Siblings
DVT (Blood Clot):	☐ Father	☐ Mother	☐ Siblings				

REVIEW OF SYMPTOMS

Are you currently having any of the following?

Blood/Lymph

Bruising/Clotting	☐Yes	☐No
Easy bleeding	☐Yes	☐No

Cardiovascular

Chest pain	☐Yes	☐No
Palpitations	☐Yes	☐No

Head/Eyes

Visual changes	☐Yes	☐No
Light sensitivity	☐Yes	☐No
Blurred vision	☐Yes	☐No
Double vision	☐Yes	☐No
Headaches	☐Yes	☐No

Respiratory

Cough	☐Yes	☐No
Wheezing	☐Yes	☐No
Coughing blood	☐Yes	☐No
Snoring	☐Yes	☐No

Skin

Bruising	☐Yes	☐No
Rashes	☐Yes	☐No
Skin lesions	☐Yes	☐No
Abnormalities	☐Yes	☐No

Gastrointestinal

Stomach pain	☐Yes	☐No
Weight gain	☐Yes	☐No
Weight loss	☐Yes	☐No
Nausea	☐Yes	☐No
Vomiting	☐Yes	☐No
Diarrhea	☐Yes	☐No
Trouble swallowing	☐Yes	☐No

Musculoskeletal

Hand/foot swelling	☐Yes	☐No
Back/neck problems	☐Yes	☐No

Ears/Nose/Throat

Easy bleeding	☐Yes	☐No
Face or neck lumps	☐Yes	☐No
Nose bleeds	☐Yes	☐No

Neurological

Muscle weakness	☐Yes	☐No
Numbness/tingling	☐Yes	☐No
Dizziness/instability	☐Yes	☐No
Lightheadedness	☐Yes	☐No

Endocrine

Heat or cold intolerance	☐Yes	☐No

Other medical problems not listed above: _____