

WILSON MEDICAL ASSOCIATES, P.A.

Patient Number _____

Today's Date _____

PATIENT INFORMATION SHEET

Name _____ Employer _____

Date of Birth _____ Marital Status _____

Height _____ Weight _____

--PAST HISTORY (check all that apply):

Diabetes	_____	Gastrointestinal Diseases	_____
High Cholesterol	_____	Kidney or Bladder Disease	_____
Emphysema	_____	Psychological Problems	_____
Neurological Disease	_____	Heart Problems	_____
High Blood Pressure	_____		
Cancer	_____	If yes, type	_____
Arthritis	_____	If yes, type	_____

--"IMMEDIATE" FAMILY HISTORY (Mother, Father, Brother, Sister) (circle all that apply)

Diabetes	None	Mother	Father	Brother	Sister
Heart Disease	None	Mother	Father	Brother	Sister
Cancer	None	Mother	Father	Brother	Sister
Alzheimer's Disease	None	Mother	Father	Brother	Sister

Other (list disease and who it affected): _____

--Allergies and The Reaction You Have:

--Past Surgeries:

--Personal Habits (circle all that apply):

Smoking (how much, if stopped – how long) _____
 Alcohol (if stopped, how long) _____
 Drugs (if stopped, how long) _____

Are you on any special diet and if so what type: _____

Date of Last Tetanus Shot: _____

Have you had the pneumonia vaccine (if over 65 years of age)? Yes No

Female Patients:

--How many pregnancies have you had: _____ How many deliveries? _____

--What form of birth control do you currently use (if any)? _____