Caring Family Practice
225 Middle Country Rd./Suite 3
Middle Island, NY 11953

PATIENT MEDICAL INFORMATION FORM

Today's Date: ____________________

Patient Name: ____

Date of Birth: ________________ Occupation: ________________________ For how long? _____

Allergies: Are you allergic to any medicines? Circle one: Yes No If yes, please complete the following:

Medication	Type of Reaction

Medications: Please list current medicines, inhalers, over the counter medicines, vitamins, and herbals:

Medication	Dose	How often

Operations/Hospital Stays: Please list ALL operations and overnight hospital stays (not ER visits):

Operation/Stay: ____ Date: ____________

Operation/Stay: ____ Date: ____________

Operation/Stay: ____ Date: ____________

Social History:

Do you smoke? Yes No If yes, how much per day? _______ for how many years? __________

Have you ever smoked? Yes No Quit Date __________

Do you drink alcohol? Yes No If yes, how often? __________________ how much? ______________________

Do you take illicit drugs ("street drugs")? Yes No If yes, which drug? ____

Do you drink caffeinated beverages? Yes No If yes, how often? ______________ how much? ___________________

Describe your eating habits: ____

Describe your exercise routine: ____

What is your sexual preference? Male Female Bisexual

Patient's Name (page 2 of Medical Information): ____

Family History: Please answer the following questions about your family's health:

Diabetes Yes No If yes, who? _________________

High blood pressure Yes No If yes, who? ________________

Asthma Yes No If yes , who? ________________

High cholesterol Yes No If yes, who? _______________

Heart issues Yes No If yes, who? _________________

Heart Attack Yes No If yes, who? ________________

Stroke Yes No If yes, who? _________________

Depression/Anxiety Yes No If yes, who?_________________

Cancer Yes No If yes, who and what type? ____

Medical History: Have you ever been diagnosed with or are currently having any of the following symptoms? Please circle all that apply:, and when this was an issue for you (date).

HEENT:
- Headache
- Ear problems
- Nose/sinus problems
- Throat problems

Musculoskeletal:
- Back problems
- Joint Pain
- Arthritis
- Broken bones
- Osteoporosis

Endocrine:
- Diabetes
- Thyroid problems
- Tired/sluggish
- Excessive thirst

Neurologic:
- Seizures/epilepsy
- Stroke
- Loss of strength
- Loss of sensation
- Numbness/tingling
- Multiple Sclerosis

Respiratory: Asthma
- COPD
- Emphysema
- Bronchitis
- Pneumonia
- Pulmonary Embolism

Gastrointestinal:
- Abdominal Pain
- Constipation
- Diarrhea
- Colitis
- Diverticulitis
- Heartburn/reflux
- Ulcers
- Hemorrhoids
- Change in Bowel Habits

Genitourinary/GYN:
- Bladder infections
- Kidney stones
- Prostate infections
- Ovary problems
- Uterine problems
- Abnormal Pap smear
- Breast lump

Blood/Immune:
- Anemia
- Blood clot
- Jaundice
- Lupus
- Liver disease

Cardiac:
- Chest Pain (Angina)
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Heart Racing
- Palpitations
- Heart Failure
- Pacemaker
- Heart Valve
- Rheumatic Fever

Skin:
- Hives
- Eczema
- Psoriasis
- Allergic rash

Psychologic:
- Anxiety
- Depression
- Bipolar disease
- Panic attacks

Communicable Diseases: Have you ever had Hepatitis? If yes, what type? A B C

Sexually Transmitted Disease? Yes No If yes, what disease? ____

Cancer: Have you ever been diagnosed with cancer? Yes No If yes, what kind? ____________________________________

What treatment did you have? ____

Date of diagnosis: _____________________________

Concerns to discuss with the doctor:

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