



Ogden Internal Medicine

Patient Information Form (age 12 and older)

Patient Name: _____

Date of Birth: _____

PCP: _____

Date: _____

Social Security #- _____

Occupation: _____

Working Retired Work # (____) _____

Whom to notify in an emergency: _____ Relationship to patient: _____

Emergency contact's home # (____) _____ Emergency contact's work # (____) _____

Drug Allergies

Latex Sensitivity: No Yes

Current Medications

Family History

	Your Father	Your Mother	Father's Parents	Mother's Parents	Your Siblings	Your Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hospitalizations

Reason	Date	Reason	Date

Are you pregnant? Yes No Date of last menstrual period _____ Planning pregnancy? Yes No

Past Medical History - (check the items that apply and then write in the date of occurrence)

- | | | |
|--|--|--|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Gallbladder disease _____ | <input type="checkbox"/> Chronic rashes _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Prostate disease _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Bladder control problems _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Sexual/Menstrual problems _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Sexually transmitted diseases _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Artery disease _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Anemia (low blood count) _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Pertussis _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Chicken pox _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Nervousness _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Stomach problems _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Bowel problems _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Scarlet fever _____ | <input type="checkbox"/> Stroke _____ |
- Do you think you have ever been exposed to TB? Yes No

Other conditions: _____

Immunization History - (check the immunizations you have received and the date of your last immunization)

- | | | |
|---|--|--|
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella) _____ | <input type="checkbox"/> TD (Tetanus/Diphtheria) _____ | <input type="checkbox"/> Flu shot _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Hepatitis A _____ | <input type="checkbox"/> Chicken pox _____ |
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) _____ | <input type="checkbox"/> Hepatitis B _____ | <input type="checkbox"/> Pneumovax _____ |



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Habits

Do you use tobacco? No Yes Type _____ Frequency _____ Amount _____

Do you use alcohol? No Yes Type _____ Frequency _____ Amount _____

Do you use other drugs? No Yes Type _____ Frequency _____ Amount _____

Do you use caffeine? No Yes Type _____ Frequency _____ Amount _____

Do you exercise? No Yes - describe: _____

Do you have eating or diet problems? No Yes - describe: _____

Do you have difficulty falling asleep? No Yes Do you have difficulty staying asleep? No Yes

Do you have problems with snoring? No Yes Do you have daytime drowsiness? No Yes

Do you have contact with blood or body fluid at work? No Yes - describe: _____

Psychosocial

Do you communicate in English: Fluent Some None Preferred Language _____

If you do not communicate in English, what do you prefer to communicate with:

ATT Language Interpretation Face-to-face interpreter

Family/Friend Interpreter: Name/Phone _____

Religious preference: _____

Advanced Directive / Organ Donation

Are you an organ donor? No Yes (sticker on chart)

Do you have an advanced directive? No Yes (copy to chart and sticker on chart)

Would you like information or assistance completing advanced directive? No Yes

Living Situation

Home Apartment Motor Home/Travel Trailer Nursing Home/Adult Foster Care (name): _____

Other _____

With whom do you live? Alone Family _____ Care giver _____ Other _____

Barriers: Stairs Other _____

Do you need help with: Eating Walking Dressing Bathing Cooking Transportation

Do you need special equipment? No Yes - describe: _____

Do you have visual problems? No Yes - describe: _____

Do you have hearing problems? No Yes - describe: _____

Other _____

Are you a care giver for another person? No Yes, for whom: _____

Do you drive a car? No Yes

Other

Is there anything in your family or home life that is upsetting you?

No Yes - describe _____

Have you recently experienced any of these feelings that bother you?

Angry Fearful Anxious Helpless Hopeless Depressed

Unsupported Alone Frustrated Other _____

Have you ever felt unsafe at home? No Yes - describe _____

Have you ever been harmed or threatened by someone close to you? No Yes - describe _____

Educational Needs

Do you have any problems that make it hard for you to learn new things? No Yes (check the items below)

Difficulty Reading Difficulty Hearing Memory Stress Other _____

How do you learn best? Reading Video Cassette Tapes Talking Computer

Is there anything not listed on this form that you would like to talk to your healthcare provider about? Yes No

(please complete the other side)