510 Maplewood Ave
Ambridge, PA 15003

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Patient Information Form

(Please Print)

Today's Date: _____/_____/_____

Patient Name: _____ _____ _____
Last First MI

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____

Gender:_____

Ethnicity:_____

Home Address: _____ City, State: _____ Zip: _____

Home Phone #: (____) ____-_____

Cell Phone #: (____) ____-_____

E-mail: _____

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____ Relationship: _____ Phone #: (____) ____-_____

Emergency Contact: _____ Relationship: _____ Phone #: (____) ____-_____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone #: (____) ____-_____

Is there a family member or other person you would like for us to share your medical information?

_____ Yes Name(s) _____

_____ No

Insurance Information

Primary Insurance Company Name: _____

Secondary Insurance Company Name: _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

TYPE 1 DIABETES	Y	N		ASTHMA	Y	N
TYPE 2 DIABETES	Y	N		HIGH BLOOD PRESSURE	Y	N
NEUROPATHY	Y	N		LIVER DISEASE	Y	N
PERIPHERAL VASCULAR DISEASE	Y	N		HEART ATTACK	Y	N
CHRONIC BACK PAIN	Y	N		SICKLE CELL DISEASE	Y	N
HIV/AIDS	Y	N		STROKE	Y	N
CANCER WHAT TYPE	Y	N		THYROID DISEASE	Y	N
DVT OR PULMONARY EMBOLISM	Y	N		BRONCHITIS/EMPHYSEMA	Y	N
HEART FAILURE	Y	N		FIBROMYALGIA	Y	N
HEPATITIS	Y	N		GOUT	Y	N
ARTHRITIS	Y	N				

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU HAVE THAT ARE NOT LISTED ABOVE

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

_____

_____

_____

_____

_____

PLEASE LIST ALLERGIES AND REACTIONS:

_____

_____

PRIOR SURGERIES:

_____

_____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

BRIEFLY DESCRIBE WHY YOU ARE BEING SEEN TODAY:

_____
_____
_____
_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE