PATIENT INFORMATION FORM

Full Name_____ **Today's Date**_____
(First) (Middle) (Last) yy / mm / dd

Date of Birth_____ **Age**_____ **Gender**_____
yy / mm / dd

Complete Address _____**Apt/Suite**_____**City**_____

Postal Code_____**Telephone Home** (____)_____ **Work** (____)_____

Occupation_____**Employer**_____

Emergency Contact: Name_____**Relation**_____ **Telephone** (____)_____

How did you hear about Dr. Jackson ?_____

MAJOR HEALTH CONCERNS IN ORDER OF IMPORTANCE

HEALTH CONCERN	SINCE	KNOWN OR SUSPECTED CAUSES

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	SINCE	REASON FOR TAKING

LIST ANY DIETARY SUPPLEMENTS OR OTHER REMEDIES YOU ARE CURRENTLY TAKING

SUPPLEMENT / REMEDY	SINCE	REASON FOR TAKING

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN ?

PHYSICIAN	FOR WHICH CONDITIONS	TREATMENT

OTHER TREATMENTS YOU ARE RECEIVING (MASSAGE, REHAB, SPECIAL DIETS ETC.)

TREATMENT or REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS DO YOU CURRENTLY HAVE OR HAVE YOU HAD IN THE PAST

☐ ANXIETY	☐ ALCOHOLISM	☐ ALLERGIES	☐ AMNESIA
☐ ANEMIA	☐ ARTHRITIS	☐ ASTHMA	☐ CANCER
☐ CHICKEN POX - ADULT	☐ COLD SORES - CHRONIC	☐ CONSTIPATION	☐ DIABETES
☐ EAR ACHES	☐ ECZEMA – CHILD OR ADULT	☐ GALL STONES	☐ GENITAL HERPES
☐ THYROID PROBLEMS	☐ VENEREAL DISEASE	☐ GOUT	☐ HAY FEVER
☐ HEART DISEASE	☐ LIVER PROBLEMS	☐ HIGH BLOOD PRESSURE	☐ HIV
☐ HYPOGLYCEMIA	☐ VERTIGO	☐ YEAST INFECTIONS	☐ INSOMNIA
☐ KIDNEY STONES	☐ KIDNEY DISEASE	☐ DEPRESSION	☐ LOW BLOOD PRESSURE
☐ MALARIA	☐ MEASLES - ADULT	☐ MISCARRIAGE	☐ MONONUCLEOSIS
☐ MULTIPLE SCLEROSIS	☐ DIARRHEA - CHRONIC	☐ PARASITES	☐ PID
☐ PERITONITIS	☐ PLEURISY	☐ PNEUMONIA	☐ PMS
☐ PROSTATITIS	☐ RHEUMATIC FEVER	☐ RUBELLA - ADULT	☐ SCARLET FEVER
☐ SEXUAL ABUSE	☐ SKIN DISEASES	☐ STREP THROAT	☐ SINUSITIS
☐ SUNSTROKE	☐ STROKE	☐ PROSTATE - ENLARGED	☐ TONSILITIS - CHRONIC
☐ TUBERCULOSIS	☐ TYPHOID FEVER	☐ VENEREAL WARTS	☐ WARTS - CHRONIC

ANY OTHER MAJOR CONDITIONS ?_____

HAVE ANY OF THE ABOVE NOTED CONDITIONS AFFLICTED OR LED TO THE DEATH OF ANY OF YOUR FAMILY MEMBERS ? _____
IF SO, INDICATE THEIR RELATIONSHIP TO YOU (E.G. MOTHER, GRANDPARENT, CHILD, ETC) AND THEIR AGE AT THE TIME OF THEIR DEATH?

_____

_____

LIST SURGERIES

OPERATION	WHEN	COMPLICATIONS (IF ANY)

LIST MAJOR INJURIES

INJURY	WHEN	LONG TERM EFFECTS (IF ANY)

☐ HAVE YOU USED TOBACCO (PAST / PRESENT) ?
☐ DO YOU DRINK ALCOHOL ?
☐ HAVE YOU DIETED OFTEN (PAST / PRESENT)?
☐ DO YOU EXERCISE REGULARLY ?
☐ DO YOU FREQUENTLY FEEL STRESSED ?
☐ DO YOU DRINK CAFFEINATED BEVERAGES (COFFEE, TEA,COLA) ?
☐ HAVE YOU USED RECREATIONAL DRUGS (PAST / PRESENT) ?
☐ HAVE YOU BEEN EXPOSED TO SECOND HAND SMOKE ?
☐ HAVE YOU BEEN EXPOSED TO CHEMICALS OR RADIATION (PAST / PRESENT) ?

WHAT VACCINATIONS HAVE YOU HAD?

_____

ANY ADVERSE SIDE EFFECTS FROM VACCINATIONS?

_____

WHAT IS YOUR:

WEIGHT NOW_____ WEIGHT ONE YEAR AGO_____ MAXIMUM WEIGHT_____
IDEAL WEIGHT_____ HEIGHT_____
AGE OF FIRST MENSES_____ NUMBER OF PREGNANCIES_____

HOW MANY CUPS OF FLUID DO YOU DRINK EACH DAY EXCLUDING COFFEE, TEA AND POP?

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