Medical Information Sheet

CODE STATUS

Patient name_____ Date of Birth _____

Social Security Number_____

Address_____

Preferred Language_____

Medical Contact #1

Name_____ Cell #_____ Work # _____

Address _____

Medical Contact #2

Name_____ Cell #_____ Work # _____

Address _____

Primary Doctor_____ Phone _____

Specialist _____ Phone _____ Specialty_____

Specialist _____ Phone _____ Specialty_____

Specialist _____ Phone _____ Specialty_____

Any Other Facilities with Medical Records

Name of Facility_____ State____ Number_____

HIPAA Form on File Y___ N___ Type of files_____

Name of Facility_____ State____ Number_____

HIPAA Form on File Y___ N___ Type of files_____

Name of Facility_____ State____ Number_____

HIPAA Form on File Y___ N___ Type of files_____

Medical Diagnoses

_____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgeries

_____ Date_____ Surgeon_____
_____ Date_____ Surgeon_____
_____ Date_____ Surgeon_____
_____ Date_____ Surgeon_____
_____ Date_____ Surgeon_____

Medications

_____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Gynecological History for Female Patients

Pregnancies_____ Births_____ Last PAP_____
Menopausal? Y__ N___ Birth Control N____ Y ___ Type_____

Allergies

Medication	What happens

Immunizations

Immunization	Date
Childhood	Fully Vaccinated? Yes____ No___ Missed_____
Pneumonia	
Shingles	
Hep B	
Flu	
Tetanus Booster	
COVID	

Social History

Tobacco (smoke, vape, chew): Current _____packs x ____ years. Quit Date_____

Alcohol use _____/ Day/week/year

Marijuana use_____

Illicit drug use including misuse of prescription drugs _____

Living situation _____

Employment/Possible workplace exposures_____

_____

Hobbies or habits with possible exposures_____

_____

Dietary issues/preferences_____

_____

Clergy to call in emergency _____ Number _____

Alternate medications/practices_____

_____