ID Doctors, PA

Infectious Disease Doctors, PA

Confidential Health Information

Patient's Name: ___________________________ Age: __________ Date: ________________

Weight: _____________________________ Height: _______________________________

What **Health Problem** brought you here today?

____

Do you or any family member have a history of…..? *(Please Circle One)*

	Patient		**Family Member**		
Seizures	No	Yes	No	Yes	_____________
Lung Disease	No	Yes	No	Yes	_____________
Heart Attack	No	Yes	No	Yes	_____________
Heart Disease	No	Yes	No	Yes	_____________
Chest Pain	No	Yes	No	Yes	_____________
Cancer	No	Yes	No	Yes	_____________
Liver Disease/Hepatitis/Cirrhosis	No	Yes	No	Yes	_____________
Kidney/Bladder Disease	No	Yes	No	Yes	_____________
Stomach Disease	No	Yes	No	Yes	_____________
Bowel Disease	No	Yes	No	Yes	_____________
Diabetes	No	Yes	No	Yes	_____________
High Blood Pressure	No	Yes	No	Yes	_____________
Are you Pregnant?*(Female Patients Only)*	No	Yes	If yes, how far along:		___________
Recurrent Fevers / Night Sweats?	No	Yes	No	Yes	_____________
Sexually Transmitted Diseases	No	Yes	No	Yes	_____________

Other ____

What is your sexually orientation? *(Please Circle One)* Bisexual/Homosexual/Heterosexual

Do you use tobacco products?	No	Yes	If yes, how often?_______________
Do you use non-prescribed or Illegal drugs?	No	Yes	If yes, how often? ______________
Do you drink liquor/beer/wine?	No	Yes	If yes, how often? ______________

Are you having any problems with…? *(Please Circle One)*

Urination	No	Yes	Diarrhea	No	Yes
Constipation	No	Yes	Swallowing	No	Yes
Breathing	No	Yes	Fevers	No	Yes
Night Sweats	No	Yes	Skin Rashes	No	Yes
Hearing	No	Yes	Vision	No	Yes

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Confidential Health Information Continued

Patient's Name: ___________________________ Age: _________ Date: _______________

List all Surgeries/Hospitalizations in the past 12 months:

Hospital ___________________________ Reason____________________Date___________
Hospital ___________________________ Reason____________________ Date___________
Hospital ___________________________ Reason____________________ Date__________
Hospital ___________________________ Reason____________________ Date__________
Hospital ___________________________ Reason____________________ Date__________

Immunization History

Have you had…? *(Please Circle One)*

Tetanus Vaccine in the last 10 years?	No	Yes
Pneumococcal Vaccine in the last 5 years?	No	Yes
Flu Shot in the past year?	No	Yes
Traveled out of the country recently?	No	Yes

Allergy History

List **ALL** allergies or intolerances. This includes medication, food, and/or latex.

Allergy/Intolerance___________________________Reason____________________
Allergy/Intolerance___________________________Reaction______________________
Allergy/Intolerance___________________________Reaction_____________________
Allergy/Intolerance ___________________________Reaction_______________________

Medications

List ALL prescription medications, over the counter medication and natural/herbal products you are routinely taking.

Name ___________________Dose___________Date/Time of Last Dose_____________
Name ___________________Dose___________Date/Time of Last Dose_____________
Name ___________________Dose___________Date/Time of Last Dose_____________
Name ___________________Dose___________Date/Time of Last Dose_____________
Name ___________________Dose___________ Date/Time of Last Dose_____________
Name ___________________Dose___________Date/Time of Last Dose_____________

(If you need more room, please attach additional information on separate sheet of paper.)

Are there any questions you have for the Doctor?

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I believe that all the above information is true and correct.

_______________________ ___________________________ ____________________

Patient Name *(Print Please)* Patient Signature Date