NGC Integrated Healthcare

PATIENT INFORMATION FORM

NAME: GENDER: M or F DOB: DATE: ALLERGIES:

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medication	Dosage	When taken

PERSONAL MEDICAL HISTORY: (Please check all that apply)

__ADHD __Alcoholism __Allergies, Seasonal __Anemia __Anxiety __Arrhythmia (irregular heart beat) Arthritis __Asthma __Bipolar __Bladder Problems / Incontinence Bleeding Problems __Cancer: _____ Headaches __Crohn's Disease	__COPD __Emphysema __Dementia __Depression __Diabetes: 1 or 2 __Diverticulitis __Thyroid Disorder __Ulcerative Colitis __Last Menstrual __Period Colonoscopy __Mammogram __Dexa (Bone Density) Pap
__DVT (Blood Clot) GERD (Acid Reflux) Glaucoma __Heart Disease __Heart Attack (MI) Hiatal Hernia __High Blood Pressure Kidney Stones Kidney Disease __High Cholesterol __HIV __Hepatitis __Irritable Bowel Syndrome Lupus __Liver Disease __Macular Degeneration Neuropathy __Osteopenia/Osteoporosis Parkinson's Disease Peripheral __Vascular Disease Peptic Ulcer __Psoriasis __Pulmonary Embolism (PE) __Rheumatoid Arthritis Seizure Disorder Sleep Apnea Stroke	**Other medical problems not listed above:**

Surgical History: Please list all prior surgeries and approximate dates performed.

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ Bachelor and above

Are there any vision problems that affect your communication?_____

Are there any hearing problems that affect your communication? _____

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes

Current Living Situation (Check all that apply): ☐ Single Family ☐ Multi-generational ☐ Homeless Household

☐ Shelter

☐ Skilled Nursing Facility

☐ No

☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____

Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

_____

FAMILY HISTORY: FATHER:

Alcoholism Anemia Asthma Arthritis

Living: Age _____

Bipolar Disorder
Cancer: _____ COPD/Emphysema Dementia

Deceased: Age _____

Depression Diabetes 1 or 2 DVT (Blood Clot) Heart Disease

High Cholesterol High Blood Pressure Kidney Disease Migraines

Osteoporosis Stroke
Thyroid Disorder

MOTHER:

Alcoholism Anemia Asthma Arthritis

Living: Age _____

Bipolar Disorder
Cancer: _____ COPD/Emphysema Dementia

Deceased: Age _____

Depression Diabetes 1 or 2 DVT (Blood Clot) Heart Disease

High Cholesterol High Blood Pressure Kidney Disease Migraines

Osteoporosis Stroke
Thyroid Disorder

Other:
_____

Other:
_____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____