**Patient Information Sheet**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History**: List all your past medical history:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgical History:** List all surgeries that you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications:** List any/all medications and supplements that you are taking, including dose and directions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies:** List all allergies including medications, food or environmental:

\_\_\_\_\_\_\_ No known allergies

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**Family Medical History:** Does anyone in your family have any chronic medical illnesses?

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Pregnancy:

Total # of pregnancies:\_\_\_\_\_\_\_\_\_\_ Total #living:\_\_\_\_\_\_\_\_\_\_ Total # of Ectopic: \_\_\_\_\_\_\_\_\_\_\_

Total # spontaneous abortions: \_\_\_\_\_\_\_\_\_\_ Total # induced abortions:\_\_\_\_\_\_\_\_\_\_\_

Social History:

Do you or have you ever smoked: Y or N If yes, how much per day:\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you ever used alcohol: Y or N If yes, how much per day:\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly wear seat belts: Y or N

Do you use any type of substances: If so, list.

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Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_