RANDOLPH PRIMARY CARE, PA

Patient Information Sheet

Patient Name:_____ **DOB:**_____ **Today's Date:**_____

Past Medical History: List all your past medical history:

_____

_____

_____

_____

_____

_____

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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_____

_____
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Allergies: List all allergies including medications, food or environmental:
_____ No known allergies

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

List_____
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_____
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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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_____
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Marital Status:_____
Occupation:_____