# FAMILY MEDICAL PRACTICE

# PATIENT INFORMATION SHEET

**DATE OF REGISTRATION (1ST VISIT)…………..**

NAME…………………………... ……… DATE OF BIRTH……………………..AGE………….

PARENT'S NAME (under 16yrs)………………………………………..

ADDRESS……………………………………… INSURANCE…………………………..

……………………………………… INSURANCE POLICY/ID NO……………………..

OCCUPATION………………………………….. PHONE: Home………………Work……..……….

EMAIL…………………………………………… Cell……………………..

## MEDICAL HISTORY

ALLERGIES: FOOD…………………………. DRUGS………………………………….

DIABETES
HYPERTENSION
HEART DISEASE
HIGH CHOLESTEROL
ASTHMA
KIDNEY DISEASE
MENTAL ILLNESS
CANCER
OTHER

## SURGICAL /DELIVERY HISTORY

| DATE | PROCEDURE/DELIVERY | OUTCOME | DURATION OF STAY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## MEDICATIONS CURRENTLY PRESCRIBED

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## FAMILY HISTORY

| | Parent | Bro/Sis | Maternal G'parent | Paternal G'parent | Other |
|---|---|---|---|---|---|
| DIABETES | | | | | |
| HYPERTENSION | | | | | |
| TWINS | | | | | |
| CANCER | | | | | |
| HEART DISEASE/HIGH CHOLESTEROL | | | | | |
| KIDNEY DISEASE | | | | | |
| ASTHMA | | | | | |