MT. STERLING CLINIC, PLLC PATIENT INFORMATION FORM

DATE: _____ PLEASE PRINT LEGIBLY

PATIENT NAME: _____
FIRST MIDDLE LAST

AGE: _____DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

GENDER: ___ MALE ____ FEMALE LANGUAGE SPOKEN: _____

ETHNICITY: _____ (NON-HISPANIC OR HISPANIC)

CELL PHONE: _____ HOME PHONE: _____

PREFERRED NUMBER FOR APPOINTMENT REMINDERS: _____

APPOINTMENT REMINDER METHOD: _____ TEXT _____ PHONE CALL

STREET ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE: _____

MAILING ADDRESS : _____
(IF DIFFERENT THAN STREET ADDRESS)

EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____WORK PHONE NUMBER: _____

WORK ADDRESS: _____

MARITAL STATUS: _____ SINGLE _____ MARRIED ____DIVORCED ____ WIDOWED

SPOUSE: _____

SPOUSE PHONE NUMBER: _____ WORK PHONE: _____

SPOUSE EMPLOYER: _____

EMERGENCY CONTACT: _____RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

EMERGENCY CONTACT ADDRESS: _____

DO YOU HAVE AN ADVANCED DIRECTIVE/LIVING WILL: _____ YES _____ NO

DO YOU GIVE PERMISSION TO THE MT. STERLING CLINIC, PLLC TO CONTACT YOUR PHARMACY REGARDING PRESCRIPTIONS FILLED? _____ YES ____ NO

This is to confirm that information above is correct to my knowledge and that I have read a copy of the Mt. Sterling Clinic, PLLC Notice of Privacy Practices.

_____

SIGNATURE DATE

MEDICAL HISTORY

Please check the appropriate box if you or a blood relative have ever had any of the following medical conditions:

	PATIENT	MOTHER	FATHER	SIBLING	CHILD
Heart Attack (age) ____	_____	_____	_____	_____	_____
Atrial Fibrillation	_____	_____	_____	_____	_____
Irregular Heart Beat	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____
Congestive Heart Failure	_____	_____	_____	_____	_____
Rheumatic Heart Disease	_____	_____	_____	_____	_____
Congenital Heart Disease	_____	_____	_____	_____	_____
Breast Cancer (age) ____	_____	_____	_____	_____	_____
Colon Cancer (age) _____	_____	_____	_____	_____	_____
Leukemia	_____	_____	_____	_____	_____
Melanoma (skin cancer)	_____	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____	_____
Pancreatic Cancer	_____	_____	_____	_____	_____
Any other cancer	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Colitis	_____	_____	_____	_____	_____
Crohn's Disease	_____	_____	_____	_____	_____
Colon Polyps	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____
Stomach Ulcer	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Migraines	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Goiter	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Suicide Attempt	_____	_____	_____	_____	_____
Sleep Apnea	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____
Lupus	_____	_____	_____	_____	_____
COVID	_____	_____	_____	_____	_____
Osteoarthritis	_____	_____	_____	_____	_____
Reflux/Heartburn	_____	_____	_____	_____	_____

Any other medical conditions not listed: _____

Have you ever had a heart cath? ___ Yes ___No If yes, date: _____

Have you ever had stents placed? ___ Yes ___No If yes, date: _____

Have you ever had bypass surgery? ___ Yes ___No If yes, date: _____

Have you ever had heart valve procedure or surgery? ___ Yes ___No If yes, date: _____

Do you have a pacemaker? ___ Yes ___No If yes, date: _____

Have you had a colonoscopy? ___ Yes ___No If yes, date: _____

Have you had an EGD (upper scope) ___ Yes ___No If yes, date _____

Date of last eye exam _____

IMMUNIZATIONS

Flu vaccine	___ Yes	__ No	Date: _____ (most recent)
Pneumovax	___ Yes	__ No	Date: _____
Prevnar	___ Yes	__ No	Date: _____
Tetanus	___ Yes	__ No	Date: _____
Hepatitis A	___ Yes	__ No	Date: _____
Hepatitis B	___ Yes	__ No	Dates: _____
Shingles Vaccine	___Yes	__ No	Dates: _____
Polio Vaccine	___ Yes	__ No	Date: _____
MMR	___ Yes	__ No	Date: _____
COVID Vaccine	___ Yes	__ No	Dates: _____

HOSPITALIZATIONS/SURGERIES

Please list any hospitalizations/surgeries you have had with date and location.

Hospitalization/Surgery	Date	Facility Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS:

Preferred Pharmacy: _____ Phone number: _____

Do you have any drug allergies? If so, name of medication(s):

_____

Do you usually receive antibiotics prior to dental procedures? _____

Please list all medications you are currently taking, including over the counter medications:

MEDICATION NAME **DOSE** **HOW OFTEN YOU TAKE**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SPECIALISTS:

Please list any other physicians you see:

PHYSICIAN NAME: **REASON YOU SEE THEM:**

_____

_____

_____

PERSONAL HABITS

Do you currently smoke? ___ Yes ___ No If yes, ____ Cigarettes ___ Pipe ____Cigars
For how many years? _____ Packs per day _____

Have you smoked regularly in the past? ___Yes ___ No If yes, when did you quit? _____

Do you currently use smokeless tobacco? ___ Yes ___ No Do you currently vape? ___ Yes ___ No
History of smokeless tobacco? Date Quit _____ History of vaping? Date Quit _____

Have you ever used recreational drugs? ___ Yes ___ No When? _____

Do you regularly drink alcohol? ____ Yes ____ No If yes, please answer next questions.
Beer: Bottles or cans per day ____ Wine: Glasses per day ___ Liquor: Ounces per day _____
Have you had 6 or more drinks of alcohol during a drinking session in the past year? ___ Yes ___ No

Do you awaken frequently at night? ____ Yes ____ No

Do you have more than one sex partner? ____ Yes ____ No

Has the person you live with hit or hurt you physically in the past? ____ Yes ____ No

Has any person verbally abused you? ___ Yes ____ No

FEMALE QUESTIONNAIRE

Are you pregnant or could you be?	____ Yes	____ No	
Have you had a hysterectomy?	____ Yes	____ No	If yes, date: _____
Do you still have monthly periods?	____ Yes	____ No	
Have you ever had bleeding between your periods?	____ Yes	____ No	
Do you feel bloated and irritable before your period?	____ Yes	____ No	
Have you ever had discharge from nipple(s)?	____ Yes	____ No	
Are you now or ever been on birth control pills?	____ Yes	____ No	
Do you have regular PAP Smears?	____ Yes	____ No	Last test _____
Do you have regular mammograms?	____ Yes	____ No	Last test _____
Have you had a Bone Mineral Density Test?	____ Yes	____ No	Last test _____

Number of pregnancies: ___ Live births:____ Miscarriages: __ Stillbirths: __ Premature births: __

Cesarean operations: ____ Pregnancy complications: _____

Thank you for your patience and cooperation in completing these forms. The information you provided will enable us to determine the medical care you may need.

Forms reviewed by: _____ Date: _____
Healthcare Provider Signature