Personal Information Sheet

Preferred location for your visit: ☐ Plano ☐ McKinney ☐ Texoma ☐ Allen
Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____
Gender: ☐ Male ☐ Female
1. Primary Email of Correspondence: _____
2. Best Phone number to contact you: _____ ☐ Cell ☐ Home ☐ Work ☐ Spouse
3. Alternative Phone number to contact you: _____ ☐ Cell ☐ Home ☐ Work ☐ Spouse
4. Primary Care Physician: First name: _____ Last: _____ City: _____
5. Race ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Type-Unknown
6. Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type Unknown Language: _____
7. How did you hear about our practice? ☐ Physician- First and Last name: _____
☐ Friend- First and Last name: _____ ☐ Internet Search: _____
☐ Insurance Company listing ☐ Print Ad: ☐ Other: _____
8. Briefly describe the reason for your visit with our office: _____

9. **Current Medication**- Please list any and all Current OTC and Prescription medications that you take regularly or as needed for any reason- please indicate drug name, dose and dosing instruction: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
10. Please indicate the local pharmacy you would like for us to send your Rx if needed- please indicate pharmacy name, city, address and phone number:

11. Please indicate the mail-in pharmacy you would like for us to send your long term recurrent Rx if needed- please indicate pharmacy name, city, address and phone number:

12. Please indicate if you prefer liquid or tablet forms of medication if available- ☐ Liquid ☐ Tablet
13. **Past Medical History**- Please list any resolved problems that are no longer active: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
14. **Current Medical Problems**- Please list any active medical problems that have not resolved: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
15. **Past Surgical History**- Please list the type of surgery, date, and surgeons's first, last name: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
16. **Family History**- Please list any close relative(s) (mom, dad, brother, sister) that suffers from any asthma, allergies, skin conditions, autoimmune, and/or immune deficiency states: ☐ None ☐ Unknown
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
17. **Immunization History**-
A. Are your vaccinations up to date: ☐ Yes ☐ No ☐ Unknown If no, please explain why not: _____
B. Have you received this year's annual flu shot? ☐ Yes ☐ No ☐ Unknown If yes- when: _____
C. Have you ever received the Pneumonia shot Pneumovax? ☐ Yes ☐ No ☐ Unknown If yes- when: _____
D. Have you ever received the Pneumonia shot Prevnar 13? ☐ Yes ☐ No ☐ Unknown If yes- when: _____
18. **Food Allergy**- Please list any **food** allergy/intolerance and the specific symptoms experienced: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
19. **Drug Allergy**- Please list any **drug** allergy/intolerance and the specific symptoms experienced: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____
E. _____ **F.** _____
20. **Chemical Allergy**- Please list any **chemical** allergy/intolerance and the specific symptoms experienced: ☐ None
A. _____ **B.** _____
C. _____ **D.** _____

Personal Information Sheet

Preferred location for your visit: ☐ Plano ☐ McKinney ☐ Texoma ☐ Allen

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

21. Insect Allergy- Please list any **insect** allergy/intolerance and the specific symptoms experienced: ☐ None

A. _____ **B.** _____

22. Social History- Please answer the following questions regarding the patient's social status:

A. Do you currently smoke? ☐ Yes ☐ No If yes, how long? _____ yrs

If yes, do you smoke daily? ☐ Yes ☐ No

B. Do you live with someone that smokes? ☐ Yes ☐ No If yes, how long? _____ yrs

C. Do you have a history of smoking in the past? ☐ Yes ☐ No If yes, how long? _____ yrs

D. Are you routinely exposed to animals/pets? ☐ Yes ☐ No If yes, please list the type of animal/pet:

_____

E. Are you exposed to mold? ☐ Yes ☐ No Where? _____

F. Are you exposed to fumes/strong odors? ☐ Yes ☐ No Where/What? _____

G. Are you exposed to chemicals? ☐ Yes ☐ No Where/What? _____

H. Are you routinely exposed to birds/pigeons/dove/fowl? ☐ Yes ☐ No If yes, please list: _____

I. Please note the current occupation of the patient (If Applicable): _____

23. Infection History- Please answer the following questions regarding recent past infections: ☐ None

A. Number of ear infections in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

B. Number of sinus infections in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

C. Number of episodes of sore throat in the last 12 months: _____ Treated with antibiotics? ☐ Yes ☐ No

D. Number of episodes of Pneumonia in in your lifetime: _____ Treated with antibiotics? ☐ Yes ☐ No

E. Number of episodes of Bronchitis in in your lifetime: _____ Treated with antibiotics? ☐ Yes ☐ No

F. Other major infections in your lifetime and approximate date experienced/treated: ☐ None

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

24. Please list any oral or systemic steroids that you have received in the last year with the approximate date and condition for which the steroids were prescribed for: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

25. List of antibiotic names used in the last 12 months: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

E. _____ **F.** _____

26. Review of Systems- Please check any signs/symptoms/conditions that you **currently** experience: ☐ None

Constitutional:	☐ Fatigue	☐ Night Sweats	☐ Chills	☐ Fevers	
Respiratory:	☐ Short of Breath	☐ Wheeze	☐ Cough	☐ Croup	☐ Tight Chest
GI:	☐ Heartburn	☐ Reflux	☐ Vomiting	☐ Diarrhea	☐ Trouble Swallowing
Urinary:	☐ Urinary Infection	☐ Blood in Urine	☐ Back Pain		
Frequent infections:	☐ Sinusitis	☐ Pneumonia	☐ Ear/Throat	☐ Bronchitis	☐ Skin
Musculoskeletal:	☐ Stiff/Sore Joints	☐ Muscle Pain	☐ Red Swollen Joints		
Eyes:	☐ Blurry	☐ Itch	☐ Water	☐ Red	☐ Frequent Infections
Nose:	☐ Runny	☐ Stuffy	☐ Itchy	☐ Sneeze	☐ Loss of Smell
Chest:	☐ Slow Heart Rate	☐ Palpitations	☐ Tight Chest	☐ Chest Pain	☐ Fast Heart Rate
Neuro:	☐ Numbness	☐ Seizures			
Skin:	☐ Dry	☐ Itch	☐ Swelling	☐ Rash	☐ Hives
Hematology:	☐ Unusual Bleeding	☐ Unusual Bruising	☐ Swollen Lymph Nodes		
Endocrine:	☐ Weight Gain	☐ Weight Loss	☐ Increased Thirst	☐ Cold Intolerance	☐ Heat Intolerance
Psychology:	☐ Anxious	☐ Depressed	☐ Stressed	☐ Worried	

Other: _____

27. Any other information you would like to share about your upcoming visit:

_____

Consent: The above information is correct to the best of my ability and accurately reflects my/the patient's current state of health. Please sign below if you agree to this statement.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date completed/updated: _____