O'CONNOR MEDICAL GROUP - PATIENT INFORMATION FORM

NAME: _____ DATE: _____ DOB: ____/_____/_____

REASON FOR VISIT TODAY: _____

DO YOU SEE A SPECIALIST? IF YES, PLEASE NAME: _____ REASON: _____

PREVIOUS HOSPITALIZATIONS & SURGERIES:

DATE	DIAGNOSIS	SURGERY	HOSPITAL

FAMILY HISTORY (PLEASE INCLUDE SUBSTANCE ABUSE/MENTAL HEALTH UNDER ILLNESS):

	AGE	HEALTH	ILLNESSES	LIVING/DECEASED	CAUSE OF DEATH
FATHER					
MOTHER					
SIBLINGS					
CHILDREN					

SOCIAL HISTORY:

MARITAL STATUS: _____ EMER. CONTACT: _____
CONTACT PHONE: ( ) -
OCCUPATION/FORMER (IF RETIRED): _____
HIGHEST LVL. OF EDUCATION: _____
ILLICIT DRUG USE: ◯ NO ◯ YES _____
TOBACCO USE: ◯ NO ◯ YES ◯ QUIT
*IF SMOKER: HOW OFTEN? _____ HOW LONG? _____
DAILY COFFEE/CAFFEINE INTAKE: _____ WAIST SIZE: ___
ALCOHOL: HOW MUCH? _____ HOW OFTEN? _____
EXERCISE: HOW MUCH? _____ HOW OFTEN? _____

PROSTATE EXAM: _____
COLONOSCOPY: _____
BONE DENSITY: _____
LAST TD VACCINE: _____

PETS: _____
AVG. HOURS SLEEP: ____
ARE YOU ON A SPECIAL DIET? _____

*IF DIABETIC:
LAST EYE EXAM: _____
NAME OF DOCTOR: _____
OTHER INFO:

HISTORY FEMALE

LAST MENSTRUAL PERIOD: _____
LAST PAP SMEAR: _____
MAMMOGRAM: _____
GYNECOLOGICAL EXAM: _____

PREGNANCIES? _____
FAMILY HIST. OF BREAST CANCER:
GRANDMOTHER: AGE: MOTHER: AGE:
SISTER: AGE:

LIST OF MEDICATIONS:

(INCLUDE ALL OVER THE COUNTER MEDICATIONS)

LIST OF DRUG ALLERGIES & REACTION TYPE:

SUBSTANCE ABUSE HISTORY:

DO YOU HAVE:	NEVER	IN THE PAST	CURRENTLY	ON MEDICATION	UNDER CARE
ALLERGIES	○	○	○	○	○
ARTHRITIS	○	○	○	○	○
ASTHMA	○	○	○	○	○
BACK PAIN	○	○	○	○	○
CANCER	○	○	○	○	○
CHRONIC BRONCHITIS	○	○	○	○	○
DEPRESSION	○	○	○	○	○
DIABETES	○	○	○	○	○
HEART PROBLEMS	○	○	○	○	○
HEARTBURN/ACID REFLUX	○	○	○	○	○
HIGH BLOOD PRESSURE	○	○	○	○	○
HIGH CHOLESTEROL	○	○	○	○	○
MENOPAUSE	○	○	○	○	○
MIGRAINE HEADACHES	○	○	○	○	○
OSTEOPOROSIS	○	○	○	○	○
STROKE	○	○	○	○	○
DRUG ABUSE	○	○	○	○	○
OTHER CONDITION	○	○	○	○	○