Medical Information Form

Patient Information

First Name	Last Name	Date of Birth	Gender
Jim	Johnson	17/04/1976	Male

Section One

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No ☐ Not Applicable

Are you taking oral contraceptives? ☐ Yes ☐ No ☐ Not Applicable

Are you taking any medication? ☑ Yes ☐ No

If yes, please explain:

Frusemide

Do you use any tobacco? ☑ Yes ☐ No

If yes, please explain how often and how long have you been using them:

yes. About 2 packs (20cig) every week, since i was 16

Do you use any controlled substances? ☑ Yes ☐ No

If yes, please explain what types of substances do you take, how often and how long have you been taking them:

weed couple times a month. About a gram each month, since i was 20

Do you have any allergies? ☑ Yes ☐ No

If yes, please explain what you are allergic to, and what is the allergic reaction like:

Amoxicillin

Section Two

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Psychiatric Care
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Radiation Treatment
☐ Anemia	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Angina	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Arthritis Gout	☐ Emphysema	☑ High Blood Pressure	☐ Rheumatism
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Joint	☐ Excessive Thirst	☐ Hives or Rash	☐ Shingles
☐ Asthma	☐ Fainting/Syncope	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Blood Disease	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Transfusion	☐ Frequent Diarrhea	☑ Kidney Problems	☐ Stomach Disease
☐ Breathing Problem	☐ Frequent Headaches	☐ Leukemia	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Liver Disease	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Lung Disease	☐ Tonsillitis
☐ Chest Pain	☑ Heart Attack/Failure	☐ Mitral valve Prolapse	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Osteoporosis	☐ Tumors or Growths
☐ Congenital Heart Disease	☐ Heart Pacemaker	☐ Pain in Jaw Joints	☐ Venereal Diseases
☐ Convulsions	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Jaundice

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Section Two (Continued)

Have you had any serious illness not listed above? ☐ Yes ■ No

If yes, please explain:

Additional Comments:

Section Three

Please list any past surgeries:

Month/Year	Reason	Hospital
07/2020	Deep vein thrombosis	Kansas Hospital

Please list any other hospitalization:

Month/Year	Reason	Hospital

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Sunrise	Health insurance	0234823582
Policy Number	**Group Number**	**Social Security Number**
ABC1234	C123	H32498345

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the healthcare providers of any changes in their medical status.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)
Signature of Patient, Parent or Guardian	Date
	15/01/2023