WILSON MEDICAL ASSOCIATES, P.A. **Patient Number _____**

Today's Date _____

PATIENT INFORMATION SHEET

Name _____ Employer_____
Date of Birth _____ Marital Status _____
Height _____ Weight _____

--PAST HISTORY (check all that apply):

Diabetes	_____	Gastrointestinal Diseases	_____
High Cholesterol	_____	Kidney or Bladder Disease	_____
Emphysema	_____	Psychological Problems	_____
Neurological Disease	_____	Heart Problems	_____
High Blood Pressure	_____		

Cancer _____ If yes, type _____
Arthritis _____ If yes, type _____

--"IMMEDIATE" FAMILY HISTORY (Mother, Father, Brother, Sister) (circle all that apply)

Diabetes	None	Mother	Father	Brother	Sister
Heart Disease	None	Mother	Father	Brother	Sister
Cancer	None	Mother	Father	Brother	Sister
Alzheimer's Disease	None	Mother	Father	Brother	Sister

Other (list disease and who it affected):_____
_____

--Allergies and The Reaction You Have:

_____
_____
_____
_____

--Past Surgeries:

_____
_____
_____
_____

--Personal Habits (circle all that apply):
Smoking (how much, if stopped – how long) _____
Alcohol (if stopped, how long) _____
Drugs (if stopped, how long) _____
Are you on any special diet and if so what type: _____
Date of Last Tetanus Shot: _____
Have you had the pneumonia vaccine (if over 65 years of age)? Yes No

Female Patients:
--How many pregnancies have you had: _____ How many deliveries? _____
--What form of birth control do you currently use (if any)? _____

PATIENT INFORMATION **MR#_____**

PATIENT NAME SOCIAL SECURITY NUMBER

_____ _____

PATIENT ADDRESS

_____

STREET OR P.O. BOX, CITY, STATE AND ZIP CODE

DATE OF BIRTH _____ SEX _____F _____M

DAYTIME PHONE NUMBER ALTERNATE PHONE NUMBER

_____ _____

E-MAIL ADDRESS _____

EMPLOYER EMPLOYER PHONE NUMBER

_____ _____

CONTACT IN CASE OF EMERGENCY

NAME	RELATIONSHIP	HOME/CELL PHONE	WORK PHONE
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____