## PATIENT INFORMATION:

Date: ___________

First Name: ________________________________ Last Name: ________________________________

Date of Birth: _______________________ Social Security Number: __________________________

Home Address: _______________________________________________________________________

North Address: _______________________________________________________________________

Telephone Number: Home: _________________________ Cell: ______________________________

Email Address: _______________________________________________________________________

Marital Status: Single_____ Married_____ Divorced_____ Widowed _______

Emergency Contact Name: ______________________________________________________________

Relation: _________________________________ Telephone Number: ________________________

Do you have living will? Yes/ No

Who is your health surrogate? Name: _____________________________________________________

Relation: __________________________________ Phone: ____________________________________

How do you want to be contacted? Home Telephone: _____ Cell: _____ Email: _____

Pharmacy Name: _____________________________ Telephone Number: ____________________

Pharmacy Address: ___________________________________________________________________

Primary Insurance: ________________ Policy# ___________________________ Policy Holder ( name, DOB, SSN) ___________________________________________________________________________

Secondary Insurance: _____________ Policy # _________________________ Policy Hoder ( name, DOB, SSN) ___________________________________________________________________________

Signature____________________________________ Date_______________________

North Naples Internal Medicine

## MEDICAL HISTORY:

NAME: _______________________________ Age: _________DOB: _______________Sex:___________

I am taking the following medications (including over the counter, birth control, etc)

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

I am allergic to the following (medications, food, pollens, etc and any type of reaction)

_____________________________________________________________________________________

I have / had the following medical problems

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

I had the following surgeries (include dates)

_____________________________________________________________________________________
_____________________________________________________________________________________

Last pneumonia shot: ____________Last tetanus shot: ______________ Shingles shot: _____________

Colonoscopy: _________ Results: _________________________________________________________

Last Mammography: _________Results: ___________________________________________________

Last Pap smear: _________ Have you ever had abnormal pap smear? ___________________________

My family medical history:

Father_______________________________________________________________________________

Mother______________________________________________________________________________

Siblings______________________________________________________________________________

Children_____________________________________________________________________________

Have you ever smoked/ chewed tobacco? Yes / No     Have you ever used illegal drugs? Yes / No

Do you consume alcohol? Yes/ No     Do you exercise regularly? Yes/ No

My occupations Present: ___________________ past: ___________________

Other information we should know about:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Signature____________________________________Date_______________________