CARTERSVILLE MEDICAL GROUP

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Patient Information Form

Name_____ **DOB #**_____ **Date**_____

Referring Physician_____ **Primary Care Physician**_____

Reason for being seen today: _____

_____

History of Present Illness:

- _____
- _____
- _____
- Diagnostic Test _____
- _____
- Have you ever had the same or similar condition? _____When _____
- Names of physicians that you have seen about your current condition or similar conditions in the past:
- _____
- ***Work Related*** / ***Auto Accident*** *yes no* ***Date of injury*** _____
- ***Date last worked*** _____ ***Person who released you*** _____

_____

_____

_____

Social History: Married____ Single____ Widowed____ Divorced___ Children___

Past Medical History: Age___ Race___ Sex ___ R or L Handed___

Prior Hospitalization including in and outpatient surgeries, year, X-ray and any test

_____

_____

_____

_____

- Prior illnesses:_____
- Allergies:_____

Habits:

Tobacco: Cigarettes: Never___ Quit_____ Packs / per Day ____ Cigars: _____ Oral: _____
Alcohol Use: Never____ Rarely ____ Moderately_____ Daily_____
Street Drugs: _____
TB Exposure: Yes ____ No____ If yes, when _____
HIV Exposure: Yes____ No ____ If yes, when _____

Present Medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Over the Counter Medication
(Conservative Treatment)

_____

_____

_____

_____

_____

Patient Name_____ **Date**_____

Vital Signs

Blood Pressure _____/_____ **Pulse** _____ **Weight** _____ **Height** _____

Medical History

Cancer Yes No _____
Diabetes Yes No _____
Hypertension Yes No _____
Stroke Yes No _____
Kidney Yes No _____
Vascular Disease Yes No _____
Phlebitis Yes No _____
History of Staph or Other Infections Yes No _____

Heart Disease Yes No _____
Neurological Disorders Yes No _____
Lung Trouble Yes No _____
Asthma Yes No _____
Hepatitis Yes No _____
Ulcers Yes No _____

Family Medical History

List any illnesses that run in your family:

_____
_____
_____

- **Are your parents alive? Father Yes No**_____ **Mother Yes No** _____
- **If yes, are they in good health?** _____ _____
- **If no, what was the cause of death?** _____ _____
- **Do you have brothers or sisters? Yes No How many?** _____
- **If so is their health good? Yes No** _____
- **Do you have children? Yes No How many?** _____
- **If so is their health good? Yes No** _____

Review of Systems

Constitutional Symptoms		**Genitourinary**	
Good General Health Lately	Yes No	Frequent Urination	Yes No
Recent Weight Change	Yes No	Burning or Painful Urination	Yes No
Fever	Yes No	Blood in Urine	Yes No
Headaches	Yes No	Kidney Stone	Yes No
Cardiovascular		**Hematologic / Lymphatic**	
Heart Trouble	Yes No	Anemia	Yes No
Chest Pain	Yes No	Phlebitis	Yes No
Shortness of Breath	Yes No	Slow to Heal After Cuts	Yes No
Swelling of Feet, Ankles or Hands	Yes No	Bleeding or Bruising Tendency	Yes No
Respiratory		**Psychiatric**	
Chronic or frequent coughs	Yes No	Memory loss or confusion	Yes No
Spitting up blood	Yes No	Nervousness	Yes No
Shortness of breath	Yes No	Depression	Yes No
Asthma or wheezing	Yes No	Insomnia	Yes No
Gastrointestinal		**Musculoskeletal**	
Change in bowel habits	Yes No	Joint Pain	Yes No
Nausea or vomiting	Yes No	Joint Stiffness or swelling	Yes No
Painful bowel movements	Yes No	Weakness of muscles or joints	Yes No
Rectal Bleeding	Yes No	Muscle pain or cramps	Yes No
Abdominal pain or heartburn	Yes No		
Peptic ulcer	Yes No		
Endocrine		**Neurological**	
Thyroid disease	Yes No	Frequent Headaches	Yes No
Diabetes	Yes No	Dizziness	Yes No
Heat or Cold Intolerance	Yes No	Convulsions or seizures	Yes No
Skin Becoming dryer	Yes No	Numbness or tingling	Yes No
Glandular or hormone problem	Yes No	Tremors	Yes No
		Paralysis	Yes No
		Stroke	Yes No
Physician's Signature_____		Head injury	Yes No
Date_____		Difficulty walking	Yes No