Family Practice Associates of Southern Hills
397 Wallace Road
Building C, Suite 100
Nashville, TN 37211
(615) 834-6166

DATE:_____

PATIENT INFORMATION FORM

The following information will be kept in strictest confidence, released only with your authorization.

Last Name First Middle		Birthdate	Age
Street Address		Gender M ☐ F ☐	Birthplace
City State Zip		Home phone	Work Phone
Employer Occupation		Marital Status S ☐ M ☐ W ☐ D ☐ Sep ☐	
Social Security #		Emergency Contact (name)	
Referred by		Emergency Contact (phone)	

PERSONAL HISTORY

Do you have or have you ever had any of the following conditions:

Yes	No	Condition	Yes	No	Condition
☐	☐	AIDS/HIV	☐	☐	Heart murmur
☐	☐	Alcohol/Drug problems	☐	☐	Hemorrhoids
☐	☐	Anemia/Low blood counts	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	Hernia
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Blood clots	☐	☐	High Cholesterol
☐	☐	Cancer (type:_____)	☐	☐	Infertility (difficulty getting pregnant)
☐	☐	Cataracts	☐	☐	Kidney/Bladder problems
☐	☐	Circulation problems	☐	☐	Liver disease/Jaundice/Hepatitis
☐	☐	COPD/Emphysema	☐	☐	Mental trouble/Depression/Anxiety
☐	☐	Diabetes (sugar)	☐	☐	Pneumonia
☐	☐	Easy bleeding	☐	☐	Rheumatic fever
☐	☐	Eating disorder (anorexia/bulimia)	☐	☐	Seizures/Fits/Epilepsy
☐	☐	Eczema	☐	☐	Serious injury/Serious accident
☐	☐	Genital herpes	☐	☐	Sickle cell anemia
☐	☐	Genital infections (chlamydia/gonorrhea)	☐	☐	Skin disorders
☐	☐	Genital warts/HPV	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid problem
☐	☐	Gout	☐	☐	Transfusion (year:_____)
☐	☐	Hay fever/Pollen allergy	☐	☐	Tuberculosis (TB)
☐	☐	Headaches	☐	☐	Ulcers
☐	☐	Hearing loss	☐	☐	Other (specify:_____)
☐	☐	Heart attack/Heart disease	☐	☐	Other (specify:_____)

SURGERY/HOSPITALIZATION/ACCIDENT/INJURY HISTORY

Please list any surgeries/hospitalization/accidents/injuries and the year.

Operation/Condition Requiring Hospitalization/Accident/Injury	Year

ALLERGIES

Please list any drug allergies and the type of reaction you experience with each drug.

Drug	Reaction

REVIEW OF SYMPTOMS

Please check any of the following symptoms that apply to you.

Past	Present	Symptom	Past	Present	Symptom
☐	☐	Weight change (unexpected)	☐	☐	Trouble swallowing
☐	☐	Fever	☐	☐	Heartburn
☐	☐	Chills	☐	☐	Constipation
☐	☐	Fatigue	☐	☐	Diarrhea
☐	☐	Dizziness	☐	☐	Blood in stool
☐	☐	Night Sweats	☐	☐	Black, tarry stool
☐	☐	Trouble sleeping	☐	☐	Pencil-thin stool
☐	☐	Appetite change	☐	☐	Hemorrhoids
			☐	☐	Jaundice
☐	☐	Headache	☐	☐	Nausea / Vomiting
☐	☐	Visual change	☐	☐	Vomiting of blood
☐	☐	Hearing loss	☐	☐	Stomach pain which:
☐	☐	Earache	☐	☐	Occurs after a meal
☐	☐	Ear discharge	☐	☐	Occurs with eating greasy, fried food
☐	☐	Ringing in ears	☐	☐	Awakens you at night
☐	☐	Nosebleeds	☐	☐	Is relieved by antacids
☐	☐	Sinus problems			
☐	☐	Bleeding gums	☐	☐	Seasonal / environmental allergies
☐	☐	Hoarseness	☐	☐	Red, itchy eyes
☐	☐	Sore throat			
			☐	☐	Easy bruising
☐	☐	Shortness of breath:	☐	☐	Rash
☐	☐	When doing usual work	☐	☐	Change in moles
☐	☐	When climbing one flight of stairs	☐	☐	Itchy skin
☐	☐	Which awakens you at night			
☐	☐	Cough	☐	☐	Burning when urinating
☐	☐	Coughing up blood	☐	☐	Blood in urine
☐	☐	Wheezing	☑	☐	Frequent urination
			☐	☐	Trouble starting urination
☐	☐	Chest pain or tightness:	☐	☐	Trouble holding urine
☐	☐	When walking fast or up a hill	☐	☐	Frequent nighttime urination
☐	☐	After a heavy meal			
☐	☐	When upset or exited	☐	☐	Muscle pain
☐	☐	That radiates down your arm	☐	☐	Joint pain
☐	☐	That disappears when you rest			
☐	☐	Irregular heartbeat	☐	☐	Numbness
☐	☐	Swelling of ankles	☐	☐	Weakness
			☐	☐	Seizures
☐	☐	Anxiety	☐	☐	Fainting
☐	☐	Depression			
☐	☐	Stress			

IMMUNIZATIONS

Date of last tetanus booster:_____ Date of last pneumonia vaccine:_____

PERSONAL HABITS

Do you regularly drink alcohol?	Yes ☐ No ☐	If yes, what amount?_____
Do you drink >4 cups of caffeinated beverages per day?	Yes ☐ No ☐	If yes, what amount?_____
Do you smoke?	Yes ☐ No ☐	If yes, how many packs per day?_____
		If yes, how many years?_____
Are you a former smoker?	Yes ☐ No ☐	If yes, how many packs per day?_____
		If yes, how many years?_____
Have you ever used street drugs?	Yes ☐ No ☐	If yes, what type?_____
Are you currently using street drugs?	Yes ☐ No ☐	If yes, what type?_____

FAMILY HISTORY

Relative	Age	If deceased, age at death	Medical Problems/Cause of Death
Mother			
Father			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Siblings			
Spouse			
Children			

MEDICATIONS

Please list the medications, with dosages and frequencies, that you currently use. Please include over-the-counter and herbal medications.

Medication	Dosage	Frequency

MEN ONLY

Please check any of the following symptoms that apply to you.

Past	Present	Conditions	Past	Present	Conditions
❑	❑	Loss of sexual function	❑	❑	Prostate trouble
❑	❑	Discharge from penis	❑	❑	Sexually transmitted disease
❑	❑	Lump in testicles	❑	❑	Surgery on private parts

If you are sexually active, do you use condoms? ☐ Yes ☐ No

WOMEN ONLY

Please check any of the following symptoms that apply to you.

Past	Present	Conditions	Past	Present	Conditions
❑	❑	Bleeding between periods	❑	❑	Abnormal Pap smear
❑	❑	Heavy periods	❑	❑	Breast discharge
❑	❑	Extreme menstrual pain	❑	❑	Breast lump
❑	❑	Unusual vaginal discharge	❑	❑	Painful intercourse
❑	❑	Sexually transmitted disease	❑	❑	Hot flashes

Menstrual History		Obstetric History	
Date of last menstrual period:	_____	Number of times you've been pregnant:	_____
Age at first period:	_____	Number of children born alive:	_____
Length of periods:	_____	Number of children born dead:	_____
Number of days between periods:	_____	Number of miscarriages:	_____
Age when periods stopped:	_____	Number of Caesarean sections:	_____
		Complications of pregnancy:	_____
Date of last Pap smear:	_____	Date of last mammogram:	_____
Was it normal?	☐ Yes ☐ No	Was it normal?	☐ Yes ☐ No

If you are sexually active, do you use birth control? ☐ Yes ☐ No If yes, what type?_____