Dr. Gail Jackson

# NEW PATIENT INFORMATION FORM

PLEASE PRINT

**PATIENT INFORMATION**

Name_____ LMP_____

Date of Birth____/____/_____

Medications_____ Allergies_____

_____ _____

**PATIENT HISTORY**

What is the reason for your visit today? _____

_____

_____

## PAST MEDICAL HISTORY: Please circle Yes or No for any illnesses that you have had:

| | | | | | |
|---|---|---|---|---|---|
| Anemia | Yes | No | Hepatitis | Yes | No |
| Arthritis | Yes | No | High Blood Pressure | Yes | No |
| Asthma/ Bronchitis/ Emphysema | Yes | No | Immune Disorders | Yes | No |
| Bleeding/ Bruising | Yes | No | Intestinal Problems | Yes | No |
| Blood Disorder | Yes | No | Kidney Disease | Yes | No |
| Cancer (type) | Yes | No | Liver Disease | Yes | No |
| Depression/Emotional Problems | Yes | No | Lung Disease | Yes | No |
| Diabetes | Yes | No | Skin Disease | Yes | No |
| Drug/Alcohol Dependency | Yes | No | Stroke | Yes | No |
| Epilepsy/Seizures | Yes | No | Stomach Ulcers | Yes | No |
| Hay Fever/Sinus Problems | Yes | No | Thyroid Disease | Yes | No |
| Heart Problems | Yes | No | Other | | |

Are you still having your monthly period? Yes___ No___ If Yes, date of last period:_____

Have you had a hysterectomy? Yes___ No___

Have you ever been hospitalized? Yes___ No ___ If yes, please list the date(s) and reason(s):_____

_____

_____

Have you had any surgeries? Yes____No___ If yes, please list the date(s) and type(s) of surgery:

_____

_____