WAIMEA PRIMARY CARE
PATIENT INFORMATION FORM

DOB:_____ **SSN:**_____

NAME:_____
(LAST) *(FIRST)* *(M.I)*

LIST ALL MEDICATIONS & SUPPLEMENTS THAT YOU ARE TAKING:

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY *(CHECK ALL THAT APPLY)*: **NONE**

- ☐ ADHD
- ☐ Alcoholism
- ☐ Allergies Anemia
- ☐ Anxiety Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bladder Issues
- ☐ Bleeding Issues
- ☐ Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ DVT (Clot)
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV
- ☐ IBS
- ☐ Lupus
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer
- ☐ Peripheral Vascular Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ STD: _____
- ☐ Thyroid Disorder

OTHER(S): _____

SURGICAL HISTORY: _____

SIGNATURE:_____ **DATE:**_____/_____/_____