Patient Information

for the Office of Dr. Jonathan Whitfield

Mr. Mrs. Ms. Child Sex: M F Date: _______________

Name, Last: _____________________________________ First: _____________________________ MI: ____

Address: _____________________________________City: ____________ State: ______ Zip_____________

Home Phone: ______________ Work Phone: ________________ Cell Phone: __________________

May I leave a message on your Home voice mail? Work? Cell?

Email Address ____ Fax Number ________________________

Marital Status: Single Married Divorced Widowed

Date of Birth: ____________________________ Social Security Number _____________________________

Employer Name: ________________________________ Your Occupation ____________________________

Primary Care Physician: _____________________________ Phone Number __________________________

Preferred Pharmacy: ________________________________ Phone Number __________________________

Whom may I thank for referring you?____

Guardian Information (If different from above)

Who is financially/legally responsible?____

Address: ______________________________________City: ____________ State: ______ Zip_____________

Home Phone: __________________ Work Phone: ___________________ Cell Phone ___________________

Date of Birth: __________________________________ Social Security Number ________________________

Medical Information

Current concerns:

Allergies: (list allergies and reaction):

Smoker?	Alcohol?	Illicit drugs?
How much?	How much?	What?
How often?	How often?	How often?

Current Medical Conditions:

Current Medications (dose/duration):

Past Medications (dose/duration):

Past Hospitalizations:

Past Surgeries:

Family Medical History:

Current Problems in Other Areas (check if problems in the past two weeks):

Loss of weight
Fainting
Fatigue
Anemia
Nosebleeds
Sore throats
Nasal congestion
Chronic cough
Thyroid trouble
Poor hearing
Difficulty swallowing
Asthma
Hay fever
Difficulty breathing
Allergy
Enlarged Glands
Sinus infection
Emphysema
Eczema/Hives
Heart disease
Chest pain
Shortness of breath
Angina
Low blood pressure
High blood pressure
Hardening of arteries
Stroke
Slow heart beat
Rapid heart beat
Bruise easily
Stomach aches
Nausea
Vomiting
Spitting up blood
Constipation
Diarrhea
Stomach ulcer
Hiatal hernia
Painful urination
Poor urine control
Blood in urine
Bladder infection
Kidney infection
Kidney stone
Prostate trouble
Bed-wetting
Broken bones
Arthritis
Swollen joints
Backache
Sciatica
Stiff or painful neck
Arm Pain
Knee Pain
Leg pain
Foot trouble
Swollen ankles
Ankle Pain
Headaches
Migraines
Weakness in arms
Numbness in arms/hands
Weakness in legs
Numbness in legs or feet
Convulsions
Ringing in ears

I have reviewed the questions on this form and answered them to the best of my ability.

Signature: ____ Date: ____________________
(Parent or guardian if a minor)