PATIENT INFORMATION SHEET

Last Name _____ First Name _____ M.I. _____

Social Security Number _____-___-_____ Date of Birth ___/____/_____ Sex: M F

Home Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Email:_____

Employer Name _____

Employer Address _____

City _____ State _____ Zip Code _____

Primary Insurance

Insurance Name _____ Phone Number (_____) _____-_____

Billing Address _____

City _____ State _____ Zip Code _____

Name of Insured _____ Relation to Patient _____

Insured's ID Number _____ Group Number _____

Secondary Insurance

Insurance Name _____ Phone Number (_____) _____-_____

Billing Address _____

City _____ State _____ Zip Code _____

Name of Insured _____ Relation to Patient _____

Insured's ID Number _____ Group Number _____

Emergency Contact

Name _____ Phone Number (_____) _____-_____

The above information is true and correct to the best of my knowledge.
I authorize the release of any medical or other information necessary to process claims for services rendered.
I authorize payment of medical benefits to Sunrise Internal Medicine, PC for services rendered.

Signature of Patient or Guardian _____ Date _____

NAME	DOB	ALLERGY

FAMILY HISTORY	**(IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING – PLEASE CIRCLE & INDICATE WHICH RELATIVE)**			
1) Epilepsy	6) Thyroid disease	11) Osteoporosis	16) Lipid disorder	
2) Migraine	7) Hay fever	12) Arthritis	17) Alcoholism	
3) Mental illnes	8) Asthma	13) Heart disease	18) Hepatitis	
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer	
5) Diabetes	10) Bleeding disorder	15) Hypertension	20)	

HOSPITAL ADMISSIONS **(not including pregnancies)**	**YEAR**	**ILLNESS OR OPERATION**	**YEAR**	**ILLNESS OR OPERATION**

MEDICAL HISTORY	**(INDICATE THE NATURE OF THE PROBLEM & WHEN YOU HAD IT)**

MEDICATIONS	**(LIST ALL MEDICATIONS YOU ARE NOW TAKING, INCLUDING DOSEAGE AND FREQUENCY)**	

VACCINE	**YEAR OF LAST**	**TEST / EXAM**	**YEAR OF LAST**
Tetanus / Td		Rectal / Stool / Colonoscopy	
Influenza (flu)		Cholesterol	
Pneumonia		Pap smear	
Hepatitis		Mammogram	

NAME	DOB	ALLERGY	

PROBLEMS	**(MARK 'C' FOR CURRENT PROBLEMS. CHECK '√' AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASE.)**					
☐ Fever	☐ Chills	☐ Headache				
☐ Blurry vision	☐ Double vision	☐ Eye pain				
☐ Hearing loss	☐ Ringing in ear	☐ Ear infection	☐ Sinus trouble	☐ Lesions in mouth	☐ Frequent nose bleeds	
☐ Hay fever	☐ Hoarseness	☐ Sore throats				
☐ Tremors	☐ Dizzy spells	☐ Numbness/ tingling				
☐ Excessive thirst	☐ Too hot/too cold	☐ Fatigue				
☐ Abdominal pain	☐ Nausea/vomiting	☐ Indigestion/ heartburn	☐ Hemorrhoids	☐ Blood in stool	☐ Loss of appetite	☐ Trouble swallowing
☐ Gallbladder disease	☐ Jaundice/hepatitis	☐ Diarrhea	☐ Constipation	☐ Diverticulosis		
☐ Chest pain	☐ Varicose veins	☐ High blood pressure	☐ Irregular heart beat	☐ Heart murmur	☐ Palpitations	
☐ Dry skin	☐ Boils	☐ Persistent itch	☐ Moles that have changed	☐ Rash	☐ Hives	
☐ Joint pain	☐ Neck pain	☐ Back pain	☐ Muscle aches	☐ Arthritis	☐ Osteoporosis	
☐ Urinary retention	☐ Painful urination	☐ Urinary frequency	☐ Urine leakage	☐ Urine infections	☐ Prostate problems	☐ Decrease in urine flow
☐ Wheezing	☐ Cough	☐ Shortness of breath				
☐ Swollen glands	☐ Blood clotting problems	☐ Anemia	☐ Bruise easily			
☐ Depression	☐ Anxiety	☐ Poor concentration	☐ Moodiness	☐ Sleep problems		
☐ Alcohol _____ oz. per week	☐ Coffee/tea ___ cup per day	☐ Smoke__cig/d ___# yr; quit ___yr	☐ Exercise _____	☐ Street drugs_____		
Female Menstral Flow	☐ Regular	☐ Irregular	☐ Pain/Cramps	☐ Last Period _____	☐ Days of flow _____	☐ Length of cycle _____

SYNOPSIS