

**Dr. John P. Muffoletto PATIENT INFORMATION SHEET**

(please print)

DATE \_\_\_\_\_ 2019 REFERRED BY \_\_\_\_\_

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

S.S.# \_\_\_\_\_ SEX M \_\_\_\_\_ F \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mail Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ P \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Spouse/Parent/Partner \_\_\_\_\_

S.S.# \_\_\_\_\_ DOB \_\_\_\_\_

Address(if different from above) \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse/Parent/Partner Employer \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Phone \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

ID Number \_\_\_\_\_ Group \_\_\_\_\_ Policy Holder \_\_\_\_\_

Secondary Medical Insurance \_\_\_\_\_

ID Number \_\_\_\_\_ Group \_\_\_\_\_ Policy Holder \_\_\_\_\_

I authorize Dr. Muffoletto to release any information that is required in the processing of my claim. I also authorize release of this same information to any other physician involved in my care. (A copy of this authorization is valid as the original.)

\_\_\_\_\_  
SIGNATURE OF PATIENT (Parent/Guardian, if a minor)

\_\_\_\_\_  
DATE

\*\*I do not have any objections to receiving blood products in a life threatening intraoperative situation. \_\_\_\_\_

(initial)

**MEDICAL HISTORY**

**PLEASE FILL THIS OUT COMPLETELY, YOUR ANSWERS WILL AFFECT YOUR TREATMENT**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

Reason for Consultation \_\_\_\_\_

Is this work related? Yes \_\_\_\_\_ No \_\_\_\_\_

List all current medications:

NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all current Vitamins, Herbal Supplements, Diet Aids and other Supplements.

**IMPORTANT** Circle all Diet Aids.

NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name other doctors that you have seen in the past 12 months.

DOCTOR	REASON	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all past major illnesses and hospitalizations:

DIAGNOSIS	WHERE	WHEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all past surgeries:

SURGERY	WHERE	WHEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all past broken bones and other major injuries:

INJURY	WHERE	WHEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a blood transfusion? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had any bleeding problems? Yes \_\_\_\_\_ No \_\_\_\_\_

**DRUG ALLERGIES:** YES \_\_\_\_\_ NO \_\_\_\_\_ **LATEX ALLERGY:** YES \_\_\_\_\_ NO \_\_\_\_\_

NAME OF DRUG	REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever used street or recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe circumstance: \_\_\_\_\_

Do you currently smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much? \_\_\_\_\_

If you have smoked in the past, for how long and when did you quit?  
\_\_\_\_\_

Do you now or did you ever drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

How much? \_\_\_\_\_

Do you drink caffeine beverages? Yes \_\_\_\_\_ No \_\_\_\_\_

How much? \_\_\_\_\_

Are you currently on a diet? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

**(For Women Only)**

# Pregnancies \_\_\_\_\_ # Deliveries \_\_\_\_\_ # Miscarriages/Abortions \_\_\_\_\_

Age at first pregnancy \_\_\_\_\_

Age at first period \_\_\_\_\_

Date of last period \_\_\_\_\_

Date of last Pap smear \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_

**PERSONAL HISTORY**

**(Circle any that apply to you)**

**HEENT**

Visual loss or impairment

Hearing loss or impairment

Seizures

Headaches

Fainting spells

Hoarseness

Difficulty swallowing

Neck lumps

**PULMONARY**

Abnormal chest x-ray

Emphysema

Coughed up blood

Tuberculosis

Asthma, wheezing

HIV / AIDS

**CARDIAC**

High blood pressure

Angina (chest pain)

Heart attack

Heart murmur

Enlarged heart

Irregular heart beat

Stroke

Ankle swelling

**GI**

Weight change

Heartburn

Ulcers

Internal bleeding

Gallstones

Liver problems

Cirrhosis

Hepatitis

Pancreatitis

Colon problems

Constipation

Diarrhea

Hemorrhoids

Rectal bleeding

**GU**

Kidney infections

Kidney stones

Bladder control

Difficulty urinating

**MUSCULAR-SKELETAL**

Gout	Arthritis
Back problems	Slipped disk

**ENDOCRINE**

Diabetes	Thyroid problems
High cholesterol	Cortisone use
Hormone deficiency	

**HEMATOLOGIC**

Anemia	Bleeding tendency
Blood clots	Poor clotting

**PSYCHIATRIC**

Depression	Nervous breakdown
Drug use	Alcoholism

**FAMILY HISTORY**

	Age	Current health status or cause of death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
	_____	_____
Sisters	_____	_____
	_____	_____
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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John Muffoletto, MD