CECE HUFFNAGLE RN, NP

PATIENT INFORMATION SHEET (PLEASE PRINT**)**

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NAME_______________________________________ DATE__________________

EMAIL____ BIRTH DATE____________ MARITAL STATUS___

ADDRESS____ CITY__________________________

STATE______ZIP ____________PHONE______________________________ OK to leave a voice mail Yes( ) No ( )

CREDIT CARD # (Phone Consultation Only)____EXP.________

(Please understand that this credit card number will now be on file and used for future charges unless otherwise specified)

SPOUSE ( ) PARTNER( ) PARENT'S ( ) NAME____

ADDRESS____CITY___________________________

STATE__________________ZIP __________PHONE____

EMPLOYMENT INFORMATION

EMPLOYER____OCCUPATION_____________________________________

ADDRESS____

PHONE__________________________

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, PLEASE NOTIFY: (FRIEND, NEIGHBOR OR FAMILY MEMBER NOT AT SAME ADDRESS)

NAME____

ADDRESS____

PHONE____

OTHER INFORMATION

PHARMACY____ PHONE_________________________

HOW DID YOU HEAR OF US?____

ARE YOU CURRENTLY RECEIVING HEALTH CARE FROM OTHER PROFESSIONALS?

IF SO, WHOM?____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I understand that I am responsible for payment at the time service is rendered. I also understand that I will be charged for appointments that are not cancelled within 24 hours. I further understand that I will be charged a maximum fee of $20.00 for each returned check.

SIGNATURE____ DATE_____________________

GENERAL:

Describe your general state of physical and emotional health:

Major illnesses and injuries:

Operations/Hospitalizations:

How much and in what form do you consume the following:

Tobacco	Alcohol	Caffeine
Recreational drugs	Avg. servings dairy/day	
Avg. servings red meat/week	Snack foods / refined sugars / artificial sweeteners	

Supplements (include dose per day) (If you need more space, please put on a separate piece of paper.)

List any medications you are taking:

Do you exercise regularly? (State frequency and type)

List allergies/reactions to medications, foods, plants, animals, chemicals, etc.

Substance	Reaction

Family History (Give age and state of health or cause of death)

Mother: Father:

Brothers/Sisters:

Children:

For Women:

1st day of last period Age periods first started

Age at menopause Length of cycle

Do you have: [ ] irregular periods [ ] severe cramps [ ] spotting [ ] heavy bleeding [ ] premenstrual syndrome

(Check and describe)

Sexually active? Current form of contraception

Number of pregnancies Number of births

Any complications? (Describe)

Any other female problems?

Continued on next page

Reason for your appointment: ____

HAVE YOU HAD?	**Yes**	**No**	If yes, describe
Chronic Fatigue or Weakness			
Fibromyalgia			
Poor or Excessive Appetite			
Unexplained Fevers			
Recent Gain or Loss in Weight			
Chronic Pain			
Recurrent Infection			
Recurrent Bleeding			
Sleep Problems			
Sexual Difficulties			
Emotional Stress			
Addictions			
Digestive Problems			
Any Eye Disease or Impaired Sight			
Any Ear Disease or Hearing Loss			
Trouble with Nose, Sinuses, Mouth, Throat			
Seizures (Convulsions)			
Severe Headaches			
Difficulty Swallowing			
Shortness of Breath			
Frequent Cough			
Coughing up Blood			
Pneumonia			
Asthma			
Heart Attack or Angina			
Chest Pains			
Palpitations (Fluttering Heart)			
Gallstones			
Abdominal Pain			
Ulcers			
Constipation			
Diarrhea			
Blood in Stool			
Hemorrhoids			
Difficulty in Urinating			
Kidney Stones			
Blood in Urine			
Arthritis			
Edema (Swelling)			
Jaundice or Liver Disease			
Tuberculosis			
Diabetes			
High Blood Pressure			
Thyroid Disease			
Skin Disease			
Problems with Nerves			