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Patient Information Form

Name: _____ Gender: _____ DOB: _____ Date: _____

Allergies: _____

List ALL MEDICATIONS you take, including OTC (over-the-counter) medications and vitamins. Include specific doses and when taken. If you don't know please contact your pharmacy to confirm. If you need additional space please attach page.

PERSONAL MEDICAL HISTORY: (please circle all that apply)

- | | | | |
|---------------------|------------------|------------------|---------------------|
| ADHD | COPD/Emphysema | High Cholesterol | Heart Disease |
| Eczema | Thyroid disorder | Asthma | Seizure Disorder |
| Allergies, Seasonal | Depression | Headaches | Sleep Apnea |
| Arrhythmia | Diabetes: 1 or 2 | Hives | High Blood Pressure |
| Arthritis | GERD (reflux) | DVT (blood clot) | Immune Deficiency |
| Cancer | Gout | Hepatitis | Glaucoma |

Other medical conditions not listed above: _____

SURGICAL HISTORY: (please list all prior surgeries and approximate dates performed)

SOCIAL HISTORY:

Any pets in the home? Yes / No If Yes what types? _____

Do you have a Dust Mite Cover on your mattress? Yes / No

Are your pillows and comforters: Feathered Non-Feathered Unsure?

Do you have Central A/C or Window units? _____

Bedroom Flooring Carpet Tile Laminate Wood Area rugs? Yes / No

Do you smoke? Current Former Never Type: _____

Amount per day: _____ Number of years: _____ Quit date: _____

Do others in home smoke? Yes / No

FAMILY HISTORY:

Father: Living Age _____ Deceased Age _____

Health: _____

Mother: Living Age: _____ Deceased Age: _____

Health: _____

Siblings: _____

Children: _____

Please list ALL other Medical Providers you see on a regular basis:
