Dr. John P. Muffoletto PATIENT INFORMATION SHEET
(please print)

DATE_____2024 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___ E-mail: _____

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_____
D.O.B. _____

Secondary Medical Insurance _____

ID Number _____Group _____ Policy Holder_____
D.O.B. _____

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	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

_____

John Muffoletto, MD