

Patient Information—Minor

Today's Date _____

Patient Name: _____ Nickname: _____

SS#: _____ DOB: _____ Sex: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Mothers Name: _____ DOB: _____

Home #: _____ Cell # _____ Wk# _____

Employer: _____ Occupation: _____

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____

SS#: _____

Fathers Name: _____ DOB: _____

Home #: _____ Cell # _____ Wk# _____

Employer: _____ Occupation: _____

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____

SS#: _____

Emergency Contact: _____ Phone #: _____

Medicare/Insurance Authorization

I request that payment of authorized Medicare/ Insurance benefits be made either to me or on my behalf to Dr. E. David Pampe for any services furnished to me by his office. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on approved medical claim forms, my signature authorizes releasing of information to the insurer or agency shown on such form.

Patient Name Parent/Guardian Signature Date



Name _____ SS# _____ Date _____
 Address _____ Occupation _____
 Phone (home) _____ (work) _____ Date of birth _____ Age _____
 Chief complaint _____

DRUG ALLERGIES

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Gallbladder disease _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Prostate disease _____ | <input type="checkbox"/> Scarlet fever _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Bowel irregularity _____ | <input type="checkbox"/> Chronic rashes _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Incontinence _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Sexual/menstrual dysfunction _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI disorder _____ | <input type="checkbox"/> Nervousness _____ | <input type="checkbox"/> Other _____ |

WOMEN ONLY: Pregnant? Yes No Planning pregnancy? Yes No
MEN ONLY: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes No
 How often does this occur? Frequently Sometimes Rarely

HABITS

- | | | |
|---|---|---|
| <input type="checkbox"/> Smoke: Packs daily _____
How long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____ |
| <input type="checkbox"/> Exercise routine: _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____ | |
| | <input type="checkbox"/> Diet: Salt intake _____
Fat intake _____ | |

Triple i / CliniForms ©2002 FP011 800-969-7237

I'm looking within

LIPITOR
atorvastatin calcium tablets

© 2007 Pfizer Inc. All rights reserved. Pfizer U.S. Pharmaceuticals