

PATIENT INFORMATION SHEET

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www.drhaydon.com

Name: _____
(Last) (First) (Middle Initial) **Today's Date**
S.S #: _____ - _____ - _____ Date of Birth: _____ Age: _____
Driver's License #: _____ State: _____ Sex: Female _____ Male _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
E-Mail Address: _____
Would you like to be notified of special offers? Yes _____ No _____
Occupation: _____ Employer: _____
Person to be contacted in case of an emergency: _____
Relationship to Patient: _____ Phone Number: _____ hm/wk/mobile _____
Specify the reason for your consultation today: _____
Who referred you to us: _____
Other family members seen by Dr. Haydon: _____

HEALTH INFORMATION

Height: _____ Weight: _____ General Doctor: _____
Current or past medical illnesses: _____

Previous Surgical Procedures: _____

Have you ever had issues with post-surgical nausea? _____
Significant Family Medical History: _____

Current Medications you are taking: _____

Allergies to Medication (What is your reaction): _____

Do you smoke? Yes/No If so, how often? _____

Do you drink alcohol? Yes/No If so, how often? _____

Pharmacy: _____ Phone #: _____

Location/Intersection: _____

Female Patients:

OBGYN doctor: _____ City: _____

Number of Pregnancies: _____ Number of live births: _____

Date of Last Mammogram: _____ Results: Normal: _____ Abnormal: _____

INSURANCE INFORMATION

Please provide insurance card to be photocopied if necessary. A referral from your primary care physician is required if you have HMO Insurance.