Infectious Disease

Professionals

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Patient Information:
Title: Mr.|Mrs.|Ms.|Miss. Circle one Date: _____

Name (Last, First): _____Middle Int: _____

Date Of Birth: _____/_____/_____ SSN: ____/_____/_____ Sex: Male/Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____
Ok to leave a voice message: yes/ no
Email Address: _____

Marital Status: Single| Married| Widowed| Divorced (circle one)

Ethnicity: Caucasian| African American | Asian | Hispanic (circle one)

Primary Care Doctor Name_____
Phone Number: _____ Fax: _____

Referring Doctor: _____ Phone Number: _____

Pharmacy Name: _____Phone Number: _____

Emergency Contact:

Name: _____ Phone Number: _____
Relationship: _____ OK to leave a voice message yes/no

Current Medications: List the name and dose

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies: List allergies and what type of reaction you have

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Immunization: Check all that apply

____ Zoster Vaccination
____ Flu Vaccination this year.
____ Hepatitis A Vaccination
____ Hepatitis B Vaccination
____ Covid-19 Vaccination; If yes How many ____ Initial Doses and ____ Boosters.
____ Pneumococcal Vaccination within the past 5 years.
____ HPV (Women)
____ HPV (Men)
Other: _____