

# PATIENT INFORMATION SHEET

## M. SCOTT HAYDON, M.D.

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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: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
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: \_\_\_\_\_  
\_\_\_\_\_

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.**