



Patient Information Sheet (PLEASE PRINT)

Date: ___/___/___

Patient's Name: _____
(Last Name) (First Name) (Middle Initial)

Address: _____
(Street) (Apt. #) (City, State, Zip Code)

Phone Number: _____
(Daytime) (Evening) (Cell/Mobile)

Social Security #: ___/___/___ DOB: ___/___/___ Marital Status: M S D W (circle one)

Email Address: _____ @ _____ Name of Spouse: _____

In Case of Emergency, Notify: (Name) _____ Phone: _____

Patient's Employer: _____ Occupation: _____

Address: _____ Phone: _____

Spouse's Employer: _____

How did you hear about us? _____

Primary Physician's Name: _____ Phone: _____

Is this visit for an injury or illness? _____
(Specify and give date of injury/illness)

Please provide your insurance card to the front desk.

Last Name: _____ First Name: _____ Policy Holders DOB: _____

Relationship to the patient (if not yourself): _____

Primary Insurance: _____ Identification: _____

Address: _____ Group or Card #: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Secondary Insurance (if applicable): _____ Group or Policy #: _____

Address: _____ State: _____ Zip: _____ Phone #: _____

I authorize the release of any information required to process claims for services rendered and hereby assign my insurance benefits to be paid directly to the O.U.C.H. I understand that I am financially responsible for any balance either not covered by my insurance or remaining as the result of information stated on this form that is inadequate, incorrect, or outdated. I understand that if I have an HMO requiring that I assign a primary care provider (PCP), I am responsible for assigning a provider of O.U.C.H. on/prior to the date of service.

Signature of Patient or the Responsible Party/Policy Holder: _____

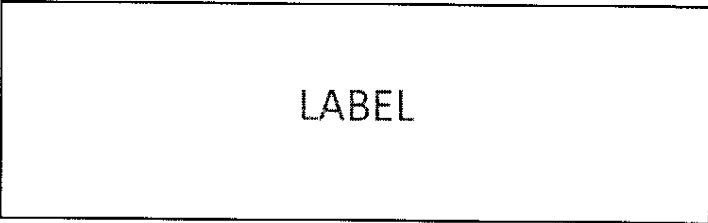
Voice mail is not a secure medium. However, many families prefer voice mail messages over "playing phone tag". Initial below the information that you permit O.U.C.H. staff to leave messages in regard to: Clinical Information: _____ Financial Information: _____

Signature of Parent/Guardian if patient is under age: _____

Witness: _____ Date: _____

Office use only: Initials of staff entering information: _____

Current (or Past) Medical Conditions AND Prior Surgeries:



Medicines:

Please list medication(s) you take?

Allergies:

Are you allergic to any medicines or other substance? No _____
 If yes, please list:

Social History:

Marital Status: _____ Occupation: _____

Do you exercise: Yes _____ No _____

Do you drink alcohol (beer, wine, liquor)? _____ Amount per week: _____

Do you smoke cigarettes/cigar/pipe? Yes _____ No _____

Amount per week: _____ (or) per day: _____

Do you chew tobacco? Yes _____ No _____

Amount per week: _____ (or) per day: _____

Do you use recreational or IV drugs? Yes _____ No _____

If yes, please list: _____

Health Maintenance(Mark N/A if not applicable):

Women:Last Pap Smear: _____ # of Pregnancies: _____
 Last Mammogram: _____ # of Live Births: _____
 Last Bone Density Scan: _____
 Type of Birth Control: _____

Men and Women:

Immunization dates (year only):Tetanus _____ Flu _____
 Pneumonia _____ HepB _____

Most recent colonoscopy (year only): _____

Men:Last PSA: _____ Last Prostate Exam: _____

Family History:Please circle any condition appearing below that any blood relative has had.

Please name the relationship [Grand Father (GF) Grand Mother (GM) Father (F), Mother (M) Brother (B) Sister (S)] and the age of onset if known.

Condition	Relative	Condition	Relative	Condition	Relative	Condition	Relative
Heart attack	_____	Prostate Cancer	_____	Rheumatoid Arthritis	_____	Hepatitis	_____
High blood pressure	_____	Melanoma	_____	Alcoholism	_____	Cirrhosis	_____
High cholesterol	_____	Colon Cancer	_____	Emphysema	_____	Anemia (low blood)	_____
Stroke	_____	Breast Cancer	_____	Asthma	_____	Easy Bleeding/bruising	_____
Tuberculosis	_____	Blood clots	_____	Diabetes	_____	Cancer	_____
Thyroid problem	_____	Other: _____	_____				

Review of Systems (circle any symptoms/problem you currently have or have had recently):

- Anemia
- Change in appetite
- Change in sleep
- Easy bruising
- Fatigue
- Fever
- Hair loss
- Excessive hair growth
- Intolerance to heat/cold
- Night sweats
- Radiation treatment
- Rheumatic fever
- Shakiness
- Sweating
- Weight loss/gain (unexplained)

Skin

- Acne
- Eczema
- Psoriasis
- Rash
- Skin cancer
- Warts
- Sensitive to Sun
- Nail changes
- New lesions/moles

Eye, Ear, Nose & Throat

- Blurry vision
- Change in vision
- Glaucoma
- Ringing in ears
- Hearing Difficulties

- Allergies/Hay fever
- Runny nose/congestion
- Sinus infections
- Hoarseness
- Swollen lymph glands

Respiratory/Lung

- Asthma
- Cold
- Coughing blood
- Emphysema
- Shortness of Breath
- Snoring
- Wheezing

Cardiovascular/Heart

- Asbestos exposure
- High blood pressure
- Chest pain/pressure
- Ankle swelling
- Blood clots/phlebitis
- Cholesterol problems
- Lightheaded spells
- Irregular Heart Beat
- Heart Murmur
- Heart disease
- Valvular disease
- Mitral valve prolapse

Gastrointestinal

- Abdominal distention
- Abdominal pain/cramping
- Blood in stool
- Change in bowel habits/stool

- Constipation
- Diarrhea
- Difficulty swallowing
- Loss of stool
- Excessive gas/bloating
- Heartburn
- Hemorrhoids
- Hepatitis
- Jaundice
- Nausea
- Rectal bleeding
- Ulcers
- Vomiting

Urinary System

- Frequent urination
- Burning on urination
- Blood in urine
- Urgency to urinate
- Urinary hesitancy
- Urinary incontinence
- Frequent bladder infections
- Kidney stones

Gynecological

- Irregular periods
- Painful periods
- Hot flashes
- Infertility
- Vaginal infections
- Uterus or tubal infection
- Sexual transmitted disease(s)
- Tremor

Musculoskeletal

- Arthritis
- Back Pain/Joint pain/stiffness
- Gout/leg pain/Muscle weakness

Mental Health

- Anxiety
- Chronic fatigue
- Depressed mood
- Difficulty concentrating
- Emotional problems
- Feeling of hopelessness
- Guilty feelings
- Hearing voices
- Insomnia

- Loss of interest in work
- Loss of sexual desire
- Social withdrawal
- Stress, severe
- Thoughts of suicide
- Visual hallucinations
- Tension/Stress
- Nervousness
- Panic attacks

Neurological

- Memory loss
- Dizziness
- Loss of sensation
- Paralysis
- Seizures
- Stroke
- Headaches/severe