PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____REFERRED BY:_____SEX:_____

NAME:_____BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____CELL PHONE:_____WORK NUMBER:_____

SS #_____MARITAL STATUS:_____EMAIL:_____

EMPLOYER:_____OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

****

NEXT OF KIN:_____BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____MALE_____FEMALE_____TELEPHONE:_____

****

EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____MALE_____FEMALE_____TELEPHONE:_____

****

RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____BIRTHDATE_____TELEPHONE:_____

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PRIMARY INSURANCE:_____ID#:_____GROUP#_____

NAME OF INSURED:_____INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ID#_____GROUP#_____

NAME OF INSURED:_____INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____DATE:_____

MEDICATION SUMMARY

PATIENT _____ DOB _____/_____/_____

PHARMACY _____PHARMACY PHONE # _____

ALLERGIES _____

_____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY

William Jack Myers, D.O.
General Surgery

(All information is confidential) Date:_____

Name:_____ Birthdate: _____/_____/_____ Age:____

MEDICAL HISTORY Check (✓) the medical conditions you have or have had:

☐ AIDS / HIV positive	☐ Diabetes	☐ Kidney Stones	☐ Thyroid problems
☐ Anemia	Type?_____	☐ Liver Disease	☐ Tonsillitis
☐ Anorexia / Bulimia	☐ Emphysema	☐ Migraine headaches	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Multiple Sclerosis	☐ Ulcers
☐ Asthma	☐ Gall Bladder Disease	☐ Pacemaker/Defibrillator	Where?_____
☐ Bleeding disorders	☐ Goiter	☐ Pneumonia	☐ Other (please list below)
☐ Blood in Urine	☐ Gout	☐ Prostate problem	_____
☐ Bronchitis	☐ Heart Disease	☐ Rheumatic Fever	_____
☐ Cancer	☐ Hepatitis	☐ Scarlet Fever	_____
☐ Chemical Dependency	☐ Hernia Site?_____	☐ Stroke	_____
☐ Chicken Pox	☐ Hypertension	☐ Suicide attempt	
	☐ Kidney Disease		

SURGICAL HISTORY

Year	Type of Surgery

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _____

FAMILY HISTORY (Fill in health information about your family.)

	Age	State of Health	Age at Death	Cause of Death			Age	State of Health	Age at Death	Cause of Death
Father						Mother				
Brothers						Sisters				

Check (✓) if your blood relatives had any of the following.

☐ Arthritis, Gout	☐ Dialysis	☐ Kidney Disease	☐ Other _____
☐ Cancer	☐ Heart Disease, Strokes	☐ Kidney Stones	☐ Other _____
☐ Diabetes	☐ High Blood Pressure	☐ Tuberculosis	☐ Other _____

SOCIAL HISTORY

Check (✓) if your work exposes you to the following.	Check (✓) which substances you use and indicate how much you use per day/week.	
Hazardous substances	Caffeine	Drugs
Other	Tobacco	Alcohol

PHYSICAL EXAM - DICTATED

(continued on next page)

REVIEW OF SYSTEMS (Check (✓) the medical conditions you have or have had in the past year.

GENERAL	GI/STOMACH	EYE, EAR, NOSE, THROAT	MEN (only)
☐ Chills / Fever	☐ Appetite Poor	☐ Bleeding Gums	☐ Breast Lump R / L
☐ Depression	☐ Bloating / Gas	☐ Blurred Vision	☐ Erection Difficulties
☐ Dizziness	☐ Constipation	☐ Crossed Eyes	☐ Lump in Testicles
☐ Fainting	☐ Diarrhea	☐ Difficult Swallowing	☐ Penis Discharge
☐ Fatigue	☐ Excessive Hunger	☐ Double Vision	☐ Sore on Penis
☐ Forgetfulness	☐ Excessive Thirst	☐ Earache	☐ Forgetfulness
☐ Headache	☐ Hemorrhoids	☐ Ear Discharge	☐ Other
☐ Loss of Sleep	☐ Indigestion/Heartburn	☐ Hay Fever	
☐ Nervousness	☐ Nausea	☐ Hoarseness	**Women (only)**
☐ Weight Gain/Loss	☐ Rectal Bleeding	☐ Loss of Hearing	☐ Abnormal Pap Smear
	☐ Stomach Pain	☐ Nose Bleeds	☐ Bleeding between periods
MUCSLE / JOINT / BONE	☐ Vomiting	☐ Persistent Cough	☐ Breast Lump R / L
Pain, Weakness, Numbness in:	☐ Vomiting Blood	☐ Ringing in Ears	☐ Extreme Menstrual Pain
☐ Arms ☐ Hips		☐ Sinus Problems	☐ Hot Flashes / Sweats
☐ Back ☐ Legs	**CARDIOVASCULAR**	☐ Vision – Flashes	☐ Nipple Discharge
☐ Feet ☐ Neck	☐ Chest Pain	☐ Vision – Halos	☐ Vaginal Discharge
☐ Hands ☐ Shoulders	☐ Chest Pressure		☐ Other
	☐ High / Low Blood Pressure	**Skin**	
GENITO-URINARY	☐ Irregular Heart Beat	☐ Bruise Easily	**Over the Counter Medicines**
☐ Frequent Urination	☐ Poor Circulation	☐ Hives / Itching	☐ Herbal Supplement
☐ Lack of Bladder Control	☐ Swelling of Ankles	☐ Change in Moles	☐ Pain Medicine (Advil,Aleve)
☐ Painful Urination		☐ Scars	☐ Other
☐ Blood in Urine		☐ Sores that won't heal	

Anything else you feel the doctor needs to know?_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Tahlequah City Hospital.

Signature:_____ Date:_____

Reviewed by:_____ Date:_____

Gastrointestinal Questionnaire

Patient Name:_____ Date:_____

When was your last: Colonoscopy_____
EGD_____
Barium Enema_____

Do you have a **Family History** with any of the following?

Colon Cancer	Yes	No
Adenomatous Polyps	Yes	No

Do you have a **Personal History** with any of the following?

Iron Deficiency Anemia	Yes	No
Colon Polyps	Yes	No
Blood in stools	Yes	No
Colon Cancer	Yes	No
Irritable Bowel Syndrome	Yes	No
Recent weight loss or gain	Yes	No
Chronic ulcerative colitis	Yes	No
Crohn's Disease	Yes	No
Diverticulitis or Diverticulosis	Yes	No
Reflux, Heartburn, Nausea	Yes	No
Trouble Swallowing	Yes	No
Peptic Ulcer Disease	Yes	No

Any other symptoms related to your visit today?

_____

_____