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:_____

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EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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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:_____

Name_____ Birthdate ____/____/_____Date_____

Reason for visit today_____

ALLERGIES Reaction to: Allergies to latex products ☐ Yes ☐ No	**CURRENT MEDICATIONS/ (Including Herbal)** Please list all or; ☐ Check (✓) if you have attached a list of medications

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

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

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		**OB/GYN HISTORY** (Please List Complications if Any)	
Check (✓) if your work exposes you to the following.	Check (✓) which substances you use and indicate how much you use per day/week.	# of Children	
Hazardous substances Other	Caffeine Tobacco	# of Pregnancies	Date of last Menstrual period?_____ Date of last Pap Smear? _____
	Drugs Alcohol	# of Miscarriages	Date of last Mammogram? _____ Are you Pregnant? _____

Name_____ Birthdate _____/_____/_____Date_____

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
MUCSLE / JOINT / BONE	☐ Stomach Pain	☐ Nose Bleeds	☐ Bleeding between periods
Pain, Weakness, Numbness in:	☐ Vomiting	☐ Persistent Cough	☐ Breast Lump R / L
☐ Arms ☐ Hips	☐ Vomiting Blood	☐ Ringing in Ears	☐ Extreme Menstrual Pain
☐ Back ☐ Legs		☐ Sinus Problems	☐ Hot Flashes / Sweats
☐ Feet ☐ Neck	**CARDIOVASCULAR**	☐ Vision – Flashes	☐ Nipple Discharge
☐ Hands ☐ Shoulders	☐ Chest Pain	☐ Vision – Halos	☐ Vaginal Discharge
	☐ Chest Pressure		☐ Other
GENITO-URINARY	☐ High / Low Blood Pressure	**Skin**	
☐ Blood in Urine	☐ 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
		☐ Sores that won't heal	

PHYSICAL EXAM – DICTATED

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:_____

MEDICATION SUMMARY

PATIENT _____ DOB _____/_____/_____

PHARMACY _____PHARMACY PHONE # _____

ALLERGIES _____

_____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY