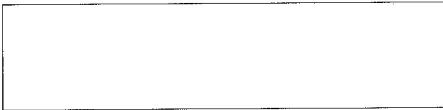

Which doctor are you seeing today?

Patient Information

Please print clearly

First Name | Middle Initial | Last Name | Maiden Name | Social Security Number — —

Street Address | City/State/Zip Code

Home Phone ( ) | Work Phone ( ) | Occupation

Age | Birthdate | Name of Doctor Who Referred You | Place of Birth

Sex: (circle) M F | Marital Status: (circle) Single Married Widowed Separated Divorced | Religion

Name of Nearest Relative | Relationship | Address (if different) | Phone Number ( )

Patient's Employer's Name

Patient's Employer's Street Address | City/State/Zip Code | Phone Number ( )

Insurance/Holder Information

Parental/Spouse's First Name & Middle Initial | Parental/Spouse's Birthdate | Social Security Number | Work Phone Number

Parental/Spouse's Employer | Street Address | City/State/Zip Code

Medical Authorization

" I request that payment of authorized Medicare benefits to be made either to me or on my behalf to Dr. Neely, Osmanski and Beth Carlson, PA-C of Cherrington Medical Associates for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needs to determine these benefits or the benefits payable for related services."

Signed | Dated

Insurance Authorization

Name of Insurance Holder

"I requested that payment of authorized Insurance benefits to be made on my behalf to Dr. Neely, Dr. Osmanski, Beth Carlson, PA-C of Cherrington Medical Associates for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Insurance company and its agents any information needed to determine these benefits payable to related services. I understand I am financially responsible to said physician for any balance not covered by my insurance carrier."

Signed

Primary Insurance Company

Second Insurance Company

Third Insurance Company

Dated

PLEASE COMPLETE REVERSE SIDE

In Case Of Emergency

Please name a person *who does not live with you*, to contact in case of an emergency or in the event that we are unable to reach you.

Name_________________________________ Relationship to you:___________________________________

Phone Number__________________________

Consent For Messages

In an effort to give you the best patient care, we sometimes need to leave messages for testing results.
Please mark the boxes as appropriate, and sign below.

☐ SVMG/CMA may leave my test results on my answering machine.

☐ SVMG/CMA may leave my test results with a family member.

☐ SVMG/CMA may leave my test results only with the person stated below:

____________________________ Phone Number (if different from my home phone): ___________________

☐ I prefer that all test results be given **only** to me. If I am unavailable, please leave a message for me to return your call.

Patient Signature: ______________________________________ Date: ______________________________

SVMG Witness: ____ Date: ______________________________

Current Medications

Please list dose and frequency.

Past Surgeries

Please list year, surgery and surgeon.

Drug Allergies

Please include drug and reaction.

Latex Allergy ☐ Yes ☐ No

Immunizations

Please give dates.

Tetanus ______

Measles/Mumps/Rubella ______

______

Polio ______

Chicken Pox ______

Hepatitis A Series ______

Hepatitis B Series ______

Pneumonia ______

Gardasil ______

Zostavax ______

Tdap ______

Last TB ______

Preventive

Please give dates.

Last PSA ______

Last Cholesterol ______

Last Rectal Exam ______

Last Colonoscopy ______

Last Flu Shot ______

Last Chest X-ray ______

DEXA ______

Other: ______

______

Habits

Do you use aspirin/ibuprofen ______

How much/how long? ______

______

Do you use tobacco/what kind? ______

______

How much/how long? ______

Do you drink alcohol? ______

How much? ______

Do you use illicit drugs? ______

What kind/how much? ______

______

Do you drink caffeine? ______

Do you exercise regularly? ______

Last eye exam? ______

Last Dental exam? ______

Married Single Divorced Widowed

Occupation? ______

Children ______ males ______ females

Gynecologic History

Gynecologist ______

Age of first period ______

Age of menopause ______

No. of pregnancies ______

No. of full term deliveries ______

Current birth control ______

Last menstrual period ______

Last mammogram ______

Last pelvic exam ______

PLEASE COMPLETE REVERSE SIDE

Reviewed with patient at appointment:

Date:	Reviewed by:

Study of Systems

Please place an X beside those conditions that affect you.

GENERAL		**HEART AND LUNGS**		**KIDNEYS**	
	Unexpected Weight Loss		High Blood pressure		Kidney Stones
	Recent Weight Gain		High Cholesterol		Kidney Disease
	Fever or Shaking Chills		Heart Disease		Frequent Urination
	Night Sweats		Heart Attack in Past		Up Nights to Urinate
	Swollen Glands		Fainting Spells		Blood in Urine
	Take Coumadin, Blood Thinners		Irregular Heartbeat		Painful Urination
			Wear Pacemaker		Slow Urination
SKIN			Chest Pain		Leakage of urine
	Severe Itching		Shortness of Breath		
	Persistent Rash		Can't Breathe when Flat	**BRAIN**	
	Changing Moles		Awaken Short of Breath		Epilepsy or Seizures
	Psoriasis		Ankles Swell		Past Stroke
			Heart Murmur		
HEAD			Mitral Valve Prolapse	**EMOTIONS**	
	Severe Headaches		Frequent Cough		Often Depressed
	Double Vision		Cough up Sputum		Cry Easily
	Glaucoma		Cough up Blood		Overly Anxious
	Cataracts		Wheezing or Asthma		Can't Handle Stress
	Difficulty Hearing		Rheumatic Fever as a Child		
	Ringing in Ears			**MEN ONLY**	
	Wear Hearing Aids	**DIGESTIVE TRACT**			Lump in Testicles
	Wear Dentures		Vomiting		Penis Discharge
	Loose Teeth		Frequent Heartburn		Erection Difficulties
	Removable Bridge		Heartburn Awakens		
	Bleeding Gums		Trouble Swallowing	**WOMEN ONLY**	
	Severe Nosebleeds		Hiatal Hernia in Past		Pregnant Now
	Frequent Sore Throats		Rectal Bleeding		Planning Pregnancy
	Persistent Hoarseness		Black Bowel Movements		Nipple Discharge
			Vomited Blood		Lump in Breast
BLOOD			Ulcers in Past		Vaginal Discharge
	Blood Transfusion past 6 months		Abdominal pain		Hot Flashes
	Prolonged Bleeding From Surgery		Diarrhea		Non-Period Bleeding
	Anemic in Past		Lost Bowel Control or Soiling		Past Menopause
	Ever Treated for Cancer		Constipation		Painful Intercourse
	Think I'm at High Risk for AIDS		Bowel habit Unpredictable		Painful Periods
			Milk or Lactose Intolerance		Change in Periods
MUSCLES AND JOINTS			Colon Polyps in Past		Past Endometriosis
	Muscle Cramps		Colon Cancer in Past		
	Muscle Weakness		Liver Disease or Jaundice	**OTHER / NOTES**	
	Arthritis or Joint Pain		Gallstones		
	Frequent Back Pain				

Thank You!!!

Past Medical History

Please check next to medical disease diagnosed by a health care professional.

_______ High blood pressure
_______ Heart attack or angina
_______ Congestive heart failure (fluid in the lungs)
_______ Irregular heart beats (requiring medication)
_______ Heart valve problem
_______ Rheumatic fever
_______ Pacemaker

_______ Ulcers (stomach, duodenum)
_______ Acid reflux (requiring medication)
_______ Irritable bowel syndrome
_______ Gallstone
_______ Hepatitis/Cirrhosis
_______ Pancreatitis
_______ Crohn's/Colitis
_______ Diverticulosis
_______ Hemorrhoids
_______ Hernias

_______ Asthma
_______ Emphysema
_______ Deep venous thrombosis (blood clots in the leg)
_______ Pulmonary embolism (blood clots in the lung)

_______ Arthritis
_______ Rheumatoid arthritis
_______ Lupus
_______ Gout

_______ Anemia
_______ Low platelet count
_______ Sickle cell disease

_______ Diabetes
_______ High cholesterol
_______ Thyroid problems

_______ Kidney failure
_______ Kidney stones
_______ Enlarged prostate

_______ Fibrocystic breast disease
_______ Abnormal pap smear
_______ Osteoporosis

_______ Stroke
_______ Seizures
_______ Dementia
_______ Multiple sclerosis
_______ Herniated disc (back)
_______ Spinal stenosis
_______ Migraine headaches

_______ Depression
_______ Panic attacks
_______ Severe anxiety (needing medication)

_______ Cataracts
_______ Glaucoma
_______ Hay fever/environmental allergies

_______ Dermatitis
_______ Psoriasis

_______ Cancer (list type below)

_______ Other: ____

_______ Living Will? Y N (Please circle)

_______ Do you use seat belts? Y N (Please circle)

_______ List any specialist you see (why?) ____

____

____

Family Health History

Do these problems run in your family?

	Father ⇧⇩	Mother ⇧⇩	Father's Father	Father's Mother	Mother's Father	Mother's Mother	___/___ Brothers ___ Sisters ___	Sons/ Daughters	Other
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon/Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleedling/ Clotting Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐

Details: ____

____

____