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WP HOSPITAL physician associates

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Patient Demographics

Patient's Last Name_____First Name_____Middle Initial _____

SSN_____Date of Birth_____Age_____Gender F M

Address_____Apt. #_____City_____State_____Zip_____

Race:

☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone_____Day Phone _____

Email Address_____Cell Phone _____

Employer_____Occupation_____☐Retired?

Employer Address _____

Emergency Contact_____/_____Phone _____
Name Relationship

Primary Care Physician Name:_____Phone:_____

Referring Physician Name:_____Phone: _____

Pharmacy Name:_____Phone: _____

Pharmacy Address: _____

Primary Insurance Coverage: _____

Policy Holder Name:_____SSN:_____DOB:_____

Secondary Insurance Coverage: _____

Policy Holder Name:_____SSN:_____DOB:_____

This visit is covered by: ☐ No Fault Insurance ☐ Workers' Compensation _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature_____Date_____

Responsible Party Name_____ Relationship _____

Patient History Form

Name:_____ **Date of Birth:** _____

Reason for Visit:

_____

_____

Please List All Current Medications			☐ **Not Currently Taking Any Medications**		
Medication Name	Dosage	How Often Taking	Medication Name	Dosage	How Often Taking

Allergies (e.g. medication, latex, egg)		☐ **No Known Allergies**	
Allergen	Type of Reaction	Allergen	Type of Reaction

Past Medical History

☐	AIDs	☐	Gout	☐	Phlebitis: ☐ Right ☐ Left ☐ Both
☐	Aneurysm	☐	Heart Murmur		
☐	Arthritis	☐	Herniated Disc : Level(s) _____	☐	Pleurisy
☐	Asthma: ☐ Adult ☐Childhood				Raynaud's Disease
		☐	Hepatitis: Type_____	☐	Sciatica
☐	Atrial Fibrillation	☐	High Blood Pressure	☐	Stroke: ☐ Right ☐ Left Area_____
☐	Bleeding Abnormality	☐	HIV		
☐	Carotid Artery Disease	☐	Kidney Disease	☐	Thoracic Outlet Disease
☐	Collapsed Lung	☐	Kidney Stones	☐	TIA: ☐ Right ☐ Left
☐	Congenital Heart Disease	☐	Liver Disease		
☐	Decreased Kidney Function	☐	Mitral Valve Proplapse	☐	Tuberculosis
☐	Diabetes: Type _____	☐	Peptic Ulcer	☐	Varicose Veins: ☐ Right ☐Left ☐ Both
☐	Emphysema	☐	Peripheral Vascular Disease: ☐Right ☐ left ☐ Both		
☐	Glaucoma			☐	Valvular Heart Disease

Patient Name:_____Date of Birth: _____

Cancer History				
Cancer Type		Year Diagnosed	Treatment (e.g. chemo, radiation)	Year Treated
☐	Leukemia			
☐	Lung			
☐	Lymphoma			
	Other Cancer:			

Past Surgical History

Please list all past surgical procedures: ☐ **No Surgical History**

Surgical Procedure	Year	Surgeon
☐ Coronary Bypass Surgery (CABG)		
☐ Coronary Stents: ☐ Metal ☐ DES		
☐ Implanted Defibrillator		
☐ Cardiac Pacemaker		
☐ Intra-arterial Stent (legs, abdomen)		
☐ Other Surgeries:		

Family History

☐ None ☐ Unknown/Adopted

☐ Cancer	☐ Diabetes	☐ Peripheral Vascular Disease
☐ Stroke	☐ Heart Disease	☐ Aneurysm

Other Family Health History:

Patient Name:_____Date of Birth: _____

Social History

Smoking Tobacco Use History (all patients age 13 and older):		If there is a history of tobacco use:
☐ Never Smoker	☐ Current Every Day Smoker	Years Used: _____
☐ Former Smoker	☐ Current Some Day Smoker	Usage Per Day:_____
☐ Unknown if Ever Smoker	☐ Smoker Current Status Unknown	Age Stopped:_____

Do You Consume Alcohol? ☐ No ☐ Yes ☐Former Frequency:_____Amount: _____

Do You Consume Caffeine? ☐ No ☐ Yes Type:_____Caffeine per day: _____

Fall Risk:

Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: _____

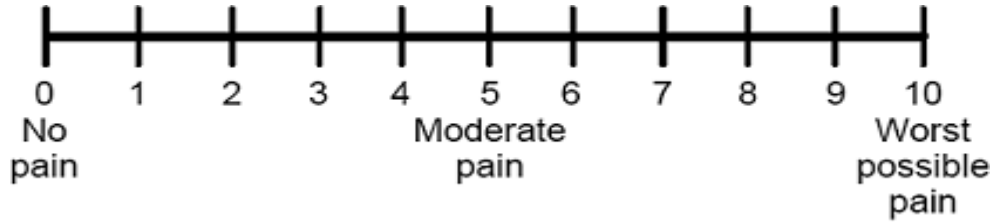
Did the fall(s) result in injury? ☐ Yes ☐ No

Advance Directives:

Do you have any Advance Directive documents? ☐ Yes ☐ No

(e.g. living will, power of attorney, do not resuscitate (DNR) orders)

Please indicate (circle) your current pain scale in relation to your current condition:



How would you prefer that we contact you?

☐ Home Phone ☐ Cell Phone ☐ Work/Day Phone ☐ Patient Portal

☐ Home Address ☐ Other _____

Cardiologist Name:_____Phone: _____

Patient Signature:_____Date: _____

Patient Representative Signature:_____Relationship: _____