REEDSPORT MEDICAL CLINIC

Lower Umpqua Hospital District

TODAY'S DATE:	**PRIMARY PHYSICIAN:**

PATIENT INFORMATION

Patient's Last name:	First:	Middle I.:	☐ Mr ☐ Mrs. ☐ Ms ☐ Miss		
How do you prefer to be addressed?	Marital status (mark one)	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow			
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	Social Security no.:	Home phone no.:			
P.O. Box:	City:	State:	Zip:	Cell / alternate phone no.:	
Occupation:	Employer:	Work no.:			
Spouse's Name:	Phone #:	Spouse DOB:	Spouse SSN:		
Clinic chosen because / Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital		
☐ Family	☐ Friend	☐ Close to home/work	☐ Internet/Website	☐ Yellow Pages	☐ Other:

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address): Relationship to patient:

Home phone no.: Work phone no.:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

IF TREATMENT IS FOR A WORK OR ACCIDENT RELATED INJURY

INSURER NAME, CLAIM # AND DATE OF INJURY:

Person responsible for bill:	Address (if different):				
Birth date:	Home phone no.:	Is this person a patient here? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:	Employer phone no.:		
Primary Insurance:	Subscriber's Name:	I.D.#:	Group #:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other:	CoPay:
Name of secondary insurance (if applicable):	Subscriber's name:	I.D.#:	Group #:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other:	

I certify that I have insurance coverage with ____ and assign directly to **Lower Umpqua Hospital District** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I request that payment of authorized Medicare and or Medigap benefits, if applicable, be made on my behalf to **Lower Umpqua Hospital District** for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient or Guardian

Date

Please print name of Patient or Guardian

Relationship to Patient

-OVER-

Confidential Health Questionnaire:

Date of last physical examination ____________________________ **What is your reason for this visit?** ____________________________

Please check symptoms you currently have or have had in the past below

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats
- ☐ Fatigue

MUSCLE/JOINT/BONE
- ☐ Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Kidney Disease
- ☐ Sexually Transmitted Disease

PULMONARY
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Short of breath
- ☐ Wake with shortness of breath
- ☐ Asthma

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Difficulty swallowing
- ☐ Taste acid in throat

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Chest pressure
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Stroke

EYES, EARS, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes/Halos
- ☐ Migraine Headaches
- ☐ Snoring
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Cataracts

DISEASES AND CONDITIONS
- ☐ HIV Positive
- ☐ AIDS
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Bleeding Disorders
- ☐ Cancer: ____________________
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Herpes

MEN ONLY
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Prostate Problem
- ☐ Breast Lump
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other: ________________________

Date of last menstrual period: __________

Date of last Pap Smear: __________

Date of last mammogram: __________

Are you pregnant? ☐ Yes ☐ No ☐ NA

DESCRIBE SERIOUS ILLNESSES OR OPERATIONS:

FAMILY HEALTH HISTORY

		AGE	AGE OF DEATH	SIGNIFICANT HEALTH PROBLEMS/CAUSE OF DEATH			AGE	AGE OF DEATH	SIGNIFICANT HEALTH PROBLEMS/CAUSE OF DEATH
Father					**Children**	☐ M ☐ F			
Mother						☐ M ☐ F			
Sibling(s)	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				**Grandfather** Maternal				
	☐ M ☐ F				**Grandmother** Paternal				
	☐ M ☐ F				**Grandfather** Paternal				

MEDICATIONS/ALLERGIES AND SENSITIVITIES

List your prescribed and over-the-counter medications or attach sheet:

List allergies and sensitivities to medications:

HEALTH HABITS

Check which you use and how often:
- ☐ Caffeine ________________
- ☐ Tobacco ________________
- ☐ Alcohol ________________
- ☐ Street Drugs ______________

Check if your work exposes you to:
- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other ______________

I certify that this information is correct to the best of my knowledge. I will not hold the clinic staff responsible for any errors I may have made in the completion of this form.

Signature____ **Date:**____________________

Reviewed____ **Date:**____________________