O'BRIEN MEDICINE

Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | **Language** ☐ English Other: _____

Race

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone ☐ Cell ☐ Pager ☐ Fax | **Work Phone** | **Other Phone**

Email Address | **Employment Status**

Employer | **Employer Phone**

Do you give O'Brien Medicine permission to contact you by __ cell, __ work phone, ___ home phone, __ email, __ other

PHYSICIAN REFERRAL INFORMATION/PHARMACY

Referring Physician

Pharmacy Name and Number

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

O'BRIEN MEDICINE

53 North High St.; Suite C Dublin, OH 43017 Phone (614) 344-7601 Fax (614) 344-0719

New Patient Medical History* - *Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/ _____ Age: ____ Sex: ____

How did you hear about our practice?

♦ *Please briefly state in the box below the reason for your visit* ♦

♦ Past Medical History ♦

Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Children:				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

O'BRIEN MEDICINE

MEDICAL RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the below mentioned office (include office name, address, phone and fax):

_____

_____

_____

Office Phone: (_____) _____- _____ Fax: (_____) _____- _____

To release any and all medical records (as specified below), including but not limited to hospitalization for diagnosis and/or treatment of psychiatric and/or medical condition, alcoholism, drug abuse, and/or HIV test results, AIDS, or AIDS related conditions to the following office:

O'Brien Medicine
53 North High St.
Suite C
Dublin, OH 43017
Phone: (614) 344-7601 Fax: (614) 344-0719

USES

The purpose of the release of this information is (please select only ONE box below):

____ Transfer of Primary Care ____ Pending Legal Action
____ Consultative Care ONLY ____ Other (please specify): _____

RESTRICTIONS

The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization will expire 1 year from the signature date below or at an earlier date, at my election (to cancel this authorization prior to the above limit, notification must be sent tot the Medical Record Department in writing and bear the patient's or legal representative's signature).

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____
Date (s) of Treatment: ALL unless otherwise specified here:_____

SIGNATURES

Patient's Signature:_____ Date:_____
Legal Representative's Signature:_____ Date:_____
Witness' Signature:_____ Date: _____