Patient Name: ________________________ DOB: __________ Entered by: _______Audited: _____

Today's date: _________

# Fountain Park Family Physicians
# Medical History Form

## Review of Systems

Are you experiencing any of the following symptoms?

**General:**
☐ Chills
☐ Excessive Weight Gain/Loss
☐ Fatigue
☐ Fever
☐ Night Sweats
☐ Weakness

**Skin:**
☐ Discoloration
☐ Easy Bruising
☐ Hives
☐ Jaundice
☐ Rash

**HEENT:**
☐ Dizziness
☐ Lightheadedness
☐ Visual Changes
☐ Hearing Problems
☐ Ringing in the Ears
☐ Postnasal Drainage
☐ Sinus Pressure
☐ Snoring
☐ Hoarseness
☐ Sore Throat

**Respiratory:**
☐ Cough
☐ Coughing Up Blood
☐ Shortness of Breath
☐ Wheezing

**Cardiovascular:**
☐ Chest Pain
☐ Difficulty Breathing on Exertion
☐ Palpitations
☐ Swelling of Extremities

**Gastrointestinal:**
☐ Abdominal Pain
☐ Constipation
☐ Diarrhea
☐ Difficulty Swallowing
☐ Food Intolerance
☐ Nausea
☐ Vomiting

**Genitourinary:**
☐ Blood in Urine
☐ Frequency
☐ Groin Pain
☐ Incontinence
☐ Pelvic Pain
☐ Urgency

**Musculoskeletal:**
☐ Back Pain
☐ Joint Pain
☐ Muscle Pain
☐ Muscle Weakness
☐ Numbness
☐ Stiffness

**Neurologic:**
☐ Headaches
☐ Memory Loss
☐Seizures
☐ Syncope
☐ Tingling
☐ Tremor
☐ Weakness

**Psychiatric:**
☐ Anxiety
☐ Depression
☐ Trouble Focusing

**Endocrine:**
☐ Excessive Thirst
☐ High Blood Sugar
☐ Low Blood Sugar

**Hematology:**
☐ Abnormal Bleeding
☐ Enlarged Lymph Nodes

Patient Name: _________________________ DOB: __________ Entered by: _______Audited: _____

## Past Medical History

Heart
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Beat
☐ Atrial Fibrillation
☐ Other_________
_________

Stomach
☐ Reflux
☐ Heartburn
☐ Ulcers
☐ Bleeding
☐ Irregular Bowel
☐ Diverticulitis
☐ Liver Disease
☐ Hepatic Failure
☐ Other_________

Endocrine
☐ Diabetes Type I
☐ Diabetes Type II
☐ Gestational Diabetes
☐ Thyroid
☐ Other________
________
________
________

Lungs
☐ Asthma
☐ COPD
☐ Emphysema
☐ Other________
________

Musculoskeletal
☐ Arthritis
☐ Gout
☐ Broken Bones
☐ Other_________
_________

Neurologic
☐ Stroke
☐ Headache
☐ Migraine
☐ Dementia

Dermatology
☐ Skin Cancer
☐ Acne
☐ Rash

Urology
☐ Kidney Stones
☐ Prostate Issues
☐ Other_________

Gynecology
☐ Endometriosis
☐ HPV

Psychiatric
☐ Memory Loss/Confusion
☐ Anxiety
☐ Depression
☐ Bipolar

Other
☐ Anemia
☐ Sinus & Allergy
☐ Other________
________

☐ Cancer: List What Type
____________________
____________________
____________________

## Social History

Tobacco: ☐ Never
☐ Current: Cigarettes ☐ Yes ☐ No Amt:____________pck/day Has been smoking for? __________
Smokeless Tobacco ☐ Yes ☐ No Amt:_____per day
Cigars ☐ Yes ☐ No Amt:_____# week
☐ Quit: Year last smoked _________ Amt: _____pck/day How many years did you smoke?_______
Children: Secondhand smoke exposure? ☐ Yes ☐ No
Alcohol use:☐ Yes ☐ No _____# drinks per day / week / occasional / social
Caffeine use: ☐ Yes ☐ No _____# drinks per day / week / occasional / social
Seatbelt use: ☐ Yes ☐ No
Exercise: ☐ Yes ☐ No Times per week: ______ Type of exercise: ____________________
Occupation: ____________________
Have you ever used **street drugs**: ☐ Yes ☐ No Which ones: ☐ Marijuana ☐ IV drugs ☐ Cocaine
☐ Amphetamines ☐ Heroin ☐ Downers ☐ Inhalants ☐ other ________________________________
Are you still using: ☐ Yes ☐ No Which ones: __________________________________________
Are you sexually active (in the last year)? ☐ Yes ☐ No ☐ Never
If yes check all that apply: ☐ 1 Partner ☐ Multiple Partner ☐ Male Partner(s) ☐ Female Partner(s)
☐ 5 or More Partners in your Lifetime
Which birth control do you use? ☐ None ☐ Condoms ☐ The Pill ☐ Vasectomy/Tubal ☐ Other_______
Is there concern for your safety? ☐ Yes ☐ No ☐ Emotional ☐ Physical ☐ Sexual Abuse

Patient Name: __________________________ DOB: __________ Entered by: _______Audited: _____

# Family History

Have any of your family members had any of the following problems?

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Asthma | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Breast Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Colon Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Depression | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Diabetes | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Elevated Lipids | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Heart Attack | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Heart Disease | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ High Blood Pressure | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Lung Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Migraines | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Osteoporosis | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Ovarian Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Prostate Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Skin Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Stroke | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Thyroid Disease | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Uterine Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Other Cancer | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Other Diagnosis | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |
| ☐ Other Mental Illness | ☐ Father | ☐ Mother | ☐ Sibling | ☐ Other_______________ |

List all **ALLERGIES** to any medications **and** the reactions: ☐ No Known Drug Allergies

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**IMMUNIZATIONS: (List Dates)**

Hepatitis A: ____________________________________________________________

Hepatitis B: ____________________________________________________________

Td- Adult Tetanus Toxoid: ________________________________________________

Influenza: ______________________________________________________________

Pneumovax: ____________________________________________________________

PPD – Tuberculin Skin Test (Include Results): ________________________________

Gardasil (HPV): _________________________________________________________

Zostavax: ______________________________________________________________

Patient Name: _________________________ DOB: __________ Entered by: _______Audited: _____

**CURRENT MEDICATIONS:** (Please include over the counter medication and food supplements.)
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
Drug Name: _________________________Dose: ________________How Often: __________________
☐ None

## Pregnancy and Birth

Date of Last Menstrual Period: ___________ Age of First Period: _______
# of Days In Flow: _______ # of Days Between Cycles: _______
Are you Menopausal ☐ Yes ☐ No Age at Onset Of Menopause: ___________
# of Pregnancies: ______ # of Live Births: _______ # of Abortions _______# of Miscarriages _______
# of Living Children ______

## Past Surgical History

**Please check or list all of the SURGERIES you have had:**

| Type of Surgery | Year |
|---|---|
| ☐Appendectomy | |
| ☐Arthroscopy (joint) | |
| ☐ Back Surgery or ☐ Neck Surgery | |
| ☐Cataract Surgery | |
| ☐Cesarean Section | |
| ☐Gallbladder Removal | |
| ☐Heart Surgery (Specify) | |
| ☐Hemorrhoids | |
| ☐Hernia (Specify) | |
| ☐Hysterectomy | |
| ☐ Knee Replacement or ☐ Hip Replacement | |
| ☐Mastectomy or Lumpectomy (Specify) | |
| ☐Polyp Removal (Colon) | |
| ☐Tonsillectomy or ☐ Adenoidectomy | |
| ☐Tubal Ligation or ☐ Vasectomy | |
| ☐Plastic Surgery (Specify) | |
| ☐Other (Specify) | |
| ☐Other (Specify) | |
| ☐Other (Specify) | |

Patient Name: _________________________ DOB: __________ Entered by: _______Audited: _____

**Have you had any orthopedic complaints resulting in radiology procedures in the last year? (ex: X-ray, MRI, CT scan)**

| Radiology Procedure | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## Health Maintenance

Date of last Mammogram: _______________(mo/yr) Date of last Bone Density: __________________(mo/yr)
Date of last Colonoscopy: _______________(mo/yr)
(Diabetic Patients) Date of last Eye Exam:___________________(mo/yr) Where: __________________________
**FOR WOMEN:** Date of last Pap Smear: _____________(mo/yr)
**FOR MEN:** Date of Last PSA level drawn (Prostate Cancer Screening):__________________________(mo/yr)

Please provide **first & last** names of all other physicians that you currently see and their specialty:
______________________________________________________________________________________
______________________________________________________________________________________

*What is your preferred pharmacy (Please include name and phone number and/or location):________________
______________________________________________________________________________________

What is your preferred mail order pharmacy (Please include name and phone number): ____________________
______________________________________________________________________________________

**Fountain Park**
**Family Physicians**
**3212 S.W. 89TH Suite 100**
**Oklahoma City, Okla. 73159**
**Phone: (405)378-3300 Fax: (405)378-3993**

**It is the policy of this Office that all payments are due at the time of visit!**

Today's Date: ______________

Are you seeing the Doctor for a work related injury? Yes □ or No □

## Patient Information:

Patient's Full Name: ________________________________Social Security#: __________________

Date of Birth: __________________ Age: _______ Sex: Male □ or Female □

Race: _____________ Ethnicity: **HISPANIC OR NON-HISPANIC** Preferred Language: ____________

Marital Status: □ Single □ Married □ Divorced □ Widowed

Patient's Current Address: ____________________________________________________________

City: _____________________________ State: ________ Zip Code: ________________

Pts Home #( )_____________ Cell#( )____________ E-mail:________________________

Is this patient a student? Yes □ or No □ If Yes: □ Full Time or Part Time □

**Employee Status**: □ Full Time □ Part Time □ Retired □ Unemployed

Patient's Employer: _________________________________ Position: ______________________

Employer's Address: __________________________ City: _________ State: ____ Zip: ______

Employer's Phone #: ( ) _______________________

Spouse's Name: _______________________________ Phone #: ( ) __________________

**Emergency Contact/ Next of Kin**:

Name: ____________________________ Phone #: ( ) _____________ Relation: ___________

## Parent or Guardian Information on Children:

Person responsible for Bill: ______________________________ Relation: ________________

S. S. #: ____________________ Date of Birth: __________ Phone #:( ) ________________

Address: ________________________________ City: ___________ State: ______ Zip: _________

Employer: __________________ Address: ______________________ Work #: ( ) ___________

Mother's name: ___________________________ D.O.B. ________ S.S. #: ___________________

Father's name: ____________________________ D.O.B.________ S.S. #: ___________________

**Insurance Information:**

Primary Insurance Coverage: ________________________ Policy or I.D. #: __________________

Cardholder's Name: _______________________ Date of Birth: ________ S.S. #:______________

Cardholder's Employer: ________________________

Is this a primary Insurance for all Family Members? □ Yes or □ No

If No, Please explain: __________________________________________________________

Secondary Insurance Coverage: ____________________ Policy or I.D. #: ___________________

Cardholder's Name: _____________________ Date of Birth: _______ S.S. #: ________________

Cardholder's Employer: ________________________

Is this a secondary Insurance for all Family Members? □ Yes or □ No

If No, Please explain: __________________________________________________________

**This page must be signed and dated!**

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and I am financially responsible for all charges, whether or not paid by the insurance.

Signature: _________________________________________ Date: _____________

**Medicare Patients Only!**

I understand in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the non-covered services. Co-Insurance and the deductible are based on the charge determination of the Medicare carrier.

Signature: _______________________________________ Date: _____________