Olathe HEALTH Physicians

*Patient Name: _____Today's Date: _____
First, MI, Last

*Home address: Street: _____

*City: _____ *State: _____ *Zip: _____

*Primary Phone: _____ Home Cell Work

Alternative Phone: _____ Home Cell Work

Referring Physician: _____ Primary care physician: _____

*Birth Date: _____ *Sex: M F

Marital Status: Single Married Divorced Widowed

Social Sec #: _____ Email _____

Occupation: Student Employed Retired Unemployed Other _____

Education Level: Student High School Some College University Degree Post-Graduate Degree

Emergency Contact: _____Relationship_____

Primary Phone: _____ Home Cell Work

Alternative Phone: _____ Home Cell Work

*Optional Demographic Information

We would appreciate you joining our effort to ensure the provision of quality healthcare of all patients by telling us your racial/ethnic background. *The choice of this information is voluntary.*

☐ Decline

Please choose the race with which you most closely identify:

Black or African American Asian White American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

Please indicate Hispanic or Latino origin (ethnicity)

Hispanic or Latino Not Hispanic or Non-Latino

What is your primary language? _____

Patient name:_____ Date:_____

***Patient Medical History** – Please check all that apply to your medical history

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back/Joint Problems
- ☐ Blood Disorders
- ☐ Cancer Type: _____
- ☐ Chronic Renal Failure
- ☐ Cirrhosis
- ☐ Colon/Bowel Problems
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's/Ulcerative Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallstones
- ☐ GERD/Stomach/Digestive Problems
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney/Bladder Problems
- ☐ Lung Disease
- ☐ Pancreatitis
- ☐ Peptic Ulcer
- ☐ Prostate Enlargement/Cancer
- ☐ Seizures
- ☐ Strokes/TIA
- ☐ Thyroid Disease
- ☐ Vision Problems Type: _____
- ☐ Other _____

☐ ***None***

***Surgical History** – Please check all that apply to your surgical past

- ☐ Adenoids
- ☐ Appendectomy
- ☐ Breast Lump
- ☐ Cataracts
- ☐ Gallbladder Removal
- ☐ Hernia
- ☐ Heart Bypass
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Mastectomy Right/Left/Both
- ☐ Orthopedic (knee/hip)
- ☐ Pacemaker
- ☐ Prostate
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Other _____

☐ ***None***

***Family History** – Please check all that apply to your family medical history

☐ Asthma	Mother	Father	Brother	Sister
☐ Cancer Type: _____	Mother	Father	Brother	Sister
☐ Colon Polyps	Mother	Father	Brother	Sister
☐ Diabetes	Mother	Father	Brother	Sister
☐ Heart Disease	Mother	Father	Brother	Sister
☐ High Blood Pressure	Mother	Father	Brother	Sister
☐ Liver Disease	Mother	Father	Brother	Sister
☐ Mental Health/Substance Abuse	Mother	Father	Brother	Sister
☐ Ulceratrive Colitis/Crohns	Mother	Father	Brother	Sister

- ☐ Unknown
- ☐ Unknown - Adopted

Physician/Provider Signature: _____ Date: _____

Patient name:_____ Date:_____

***Social History** – Please circle

Smoking/Tobacco Use: No Yes Packs per day_____ Number of years_____

Quit Date Quit _____

Alcohol Use : No Yes What type: beer liquor wine how many drinks per day?_____

Quit Date Quit _____

Caffeine Use Number of cups/drinks a day? _____

Exercise: No Yes How frequently: _____

Do you wear your seat belt? No Yes

Do you follow any special diet? No Yes

Do you use any special medical equipment at home? (oxygen, walker, CPAP, etc)?

No Yes Type _____

*Current Symptoms

Please indicate if you are *CURRENTLY* having any of the symptoms listed below.

General ☐ Decrease in appetite ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight loss ☐ Weight gain ☐ Trouble Sleeping

Eyes/ENT ☐ Blurred or double vision ☐ Diminished Vision ☐ Drainage ☐ Hoarseness ☐ Hearing loss or ringing ☐ Chronic sinus problems ☐ Nose bleeds

Respiratory ☐ Chronic Cough ☐ Wheezing ☐ Shortness of breath

Endocrine ☐ Increased thirst ☐ Cold/Heat intolerance ☐ Breast Discharge ☐ Change in menstrual cycle

Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ Pacemaker

Hematology ☐ Coumadin treatment ☐ Nose Bleeds ☐ Easy bruising ☐ Swollen glands ☐ Anemia

Genitourinary ☐ Frequent urination ☐ Burning/painful urination ☐ Blood in urine ☐ Decreased flow

Musculoskeletal ☐ Painful joints ☐ Joint swelling ☐ Muscle cramps ☐ Back pain

Skin ☐ Itching ☐ Rash ☐ Hives ☐ Dry Skin ☐ Changing Mole

Neurological ☐ Dizzy or light headed ☐ Numbness or tingling ☐ Memory loss ☐ Difficulty speaking ☐ Seizure ☐ Headaches

Mental Health ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Stress ☐ Mood changes

☐ ***No Current Symptoms***

Physician/Provider Signature: _____ Date: _____

Patient name:_____ Date:_____

Preventative Screenings/Immunizations – Please check all that apply

- ☐ Colonoscopy (>age 50) Date: _____
- ☐ Bone Density Date: _____
- ☐ Tetanus Date: _____
- ☐ Dental Exam Date: _____
- ☐ Mammography (women age 40-74) Date: _____
- ☐ Pneumonia Vaccine (>age 65) Date: _____
- ☐ Pap/Prostate Exam Date: _____
- ☐ Vision Exam Date: _____
- ☐ Any Other Tests (type/date) _____

***Medications:** List all medications you presently take. (include dosage and how often)

☐ ***Take No Medications***

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Mail Order: _____

Over-the-Counter Medications Please list any over-the-counter medications, including vitamins and supplements you presently take. (include dosage and how often)

***Allergies:** Drug/Agent Reaction

☐ ***No known Allergies***

Physician/Provider Signature: _____ Date: _____