WVUMedicine
ST. JOSEPH'S HOSPITAL

The following information is very important to your health. Please take the time to fully and accurately fill out this form

Information:

Name: (First, MI, Last)_____

Address: (Street, City, State, Zip)_____

Date of Birth:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact (Someone outside of your home):

Name:_____ Relation to you:_____

Address:_____ _____

Home Phone:_____ Cell Phone:_____

Chief Complaint:

What brings you to the office today?_____

Who referred you?_____Contact number:_____

Who is your primary care physician?_____Contact number:_____

Health Information:

Allergies (including food & medications): □ No □ Yes (list below with reaction)

_____

_____

_____

Medical History: (check the box for those that apply)

	Comments:		Comments:
□	Asthma	□	Cancer
□	Pneumonia	□	Ulcers
□	Chronic lung disease	□	Depression/Anxiety
□	Kidney infections/stones	□	Anemia/blood transfusions
□	Tuberculosis	□	Seizures/convulsions/epilepsy
□	Venereal disease	□	Bowel trouble
□	Heart trouble/murmur	□	Glaucoma
□	Diabetes	□	Arthritis/joint pain
□	High blood pressure	□	Fracture
□	Stroke	□	Hepatitis/yellow jaundice
□	Rheumatic fever	□	Thyroid disease

Medications: *include non-prescription drugs, inhalers, contraceptives, supplements you are presently taking*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History: □ None □ Yes (List below with date if known)

Surgery performed	Date:	Where was surgery done?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Name:_____

Vision History:

□ Normal □ Impaired □ Glaucoma □ Glasses □ Contacts □ Cataracts ___Right___Left
□ Artificial Eye ___Right___Left □ Blind ___Right___Left
□ Date of last exam:_____

Hearing History:

□ Normal □ Impaired ___Right___Left □ Hearing Aid ___Right___Left □ Deaf ___Right___Left
□ Date of last exam:_____

Dental History:

□ No problems □ Braces/Retainer □ Chipped tooth □ Loose tooth □ Capped tooth □ Toothache
□ Missing tooth □ Bridges ___Removable___Permanent □ Dentures ___Upper___Lower___Partial □Cavities

Family History (only include parents, grandparents, siblings or children):

Illness:	Relative:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Smoke	□ Yes	□ No	Packs per day_____ Years_____
Chew tobacco	□ Yes	□ No	Cans/Bags per day_____ Years_____
Alcohol	□ Yes	□ No	Drinks per day_____ Drinks per week _____
Drug use	□ Yes	□ No	
Seat belt use	□ Yes	□ No	
Regular exercise	□ Yes	□ No	
Present occupation	_____		
Former occupation	_____		
Is someone hurting you physically/verbally?	□ Yes	□ No	
Marital status	□ Married	□ Single □ Widowed □ Divorced	
Number of living children	_____		
Number of people in household	_____		
School completed	□ High School	□ College □ Graduate Degree □ Other:_____	

OB/GYN History

Last Menstrual Period	_____	Abortions	_____
Births	_____	Living Children	_____
Miscarriages	_____		

Last Immunization or Test

Tetanus/Diphtheria	_____	TB Skin Test	_____
Flu Shot	_____	Shingles Vaccine	_____
Hepatitis	_____	Colonoscopy	_____
TDAP	_____	Mammogram	_____
Pneumonia	_____	Digital rectal exam	_____

Have you ever had a blood transfusion? □ No □ Yes

If yes did you have a reaction □ No □ Yes (If Yes, please describe)_____

Do you have an advance directive □ No □ Yes If Yes, please bring it with you to the hospital

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Name:_____

Review of Systems:

Please check if any of the following apply to you now, in the past or often

Constitutional			Comments:
Weight loss	□ Yes	□ No	
Weight gain	□ Yes	□ No	
Fever	□ Yes	□ No	
Fatigue	□ Yes	□ No	
Eyes			Comments:
Double vision	□ Yes	□ No	
Spots before eyes	□ Yes	□ No	
Vision changes	□ Yes	□ No	
ENT/Mouth			Comments:
Earaches	□ Yes	□ No	
Ringing in ears	□ Yes	□ No	
Sinus problems	□ Yes	□ No	
Sore throat	□ Yes	□ No	
Mouth sores	□ Yes	□ No	
Dental problems	□ Yes	□ No	
Cardiovascular			Comments:
Painful breathing	□ Yes	□ No	
Chest pain	□ Yes	□ No	
Difficulty breathing on exertion	□ Yes	□ No	Intensity Level 0-10 _____
Swelling of legs	□ Yes	□ No	
Palpitations of heart	□ Yes	□ No	
Respiratory			Comments:
Wheezing	□ Yes	□ No	
Spitting up blood	□ Yes	□ No	
Shortness of breath	□ Yes	□ No	
Cough, chronic	□ Yes	□ No	
Gastrointestinal			Comments:
Diarrhea, frequent	□ Yes	□ No	
Bloody stool	□ Yes	□ No	
Nausea/vomiting	□ Yes	□ No	
Constipation	□ Yes	□ No	
Genitourinary			Comments:
Blood in urine	□ Yes	□ No	
Pain with urination	□ Yes	□ No	
Urgency	□ Yes	□ No	
Frequency of urination	□ Yes	□ No	
Incomplete emptying	□ Yes	□ No	
Stress incontinence	□ Yes	□ No	
Abnormal periods	□ Yes	□ No	
Painful intercourse	□ Yes	□ No	

Musculoskeletal			Comments:
Muscle weakness	□ Yes	□ No	

Name:_____

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Skin/Breast			Comments:
Pain in breast	□ Yes	□ No	Intensity Level 0-10 _____
Discharge	□ Yes	□ No	
Masses	□ Yes	□ No	
Rash	□ Yes	□ No	
Ulcers	□ Yes	□ No	
Neurological			Comments:
Dizziness	□ Yes	□ No	
Seizures	□ Yes	□ No	
Numbness	□ Yes	□ No	
Trouble walking	□ Yes	□ No	
Psychiatric			Comments:
Depression	□ Yes	□ No	(Are you currently receiving counseling or medications?)
Frequent crying	□ Yes	□ No	□ Yes □ No
Anxiety	□ Yes	□ No	
Bipolar	□ Yes	□ No	
Panic Attacks	□ Yes	□ No	
Schizophrenia	□ Yes	□ No	
PTSD	□ Yes	□ No	

Per our Notice of Privacy Practices, we may disclose information about this visit to your Primary Care Provider and/or the Referring Provider. If you wish to restrict access to your personal health information, you may do so by contacting our Health Information Management department in writing. For more information, please call Health Information Management at 304-473-2161.

Completed by: □ Patient □ Office Nurse □ Physician

I attest that the above information is true and correct to the best of my belief.

Signature of patient: _____ Date_____

Date reviewed by physician with patient: _____

Physician Signature:_____ Date:_____