

Medication allergies or side effects:

___ Check here if you have no medication allergies or side effects.

<u>MEDICATION</u>	<u>ALLERGIC REACTION</u>	<u>SIDE EFFECT</u>
1		
2		
3		
4		
5		

MEDICAL DIAGNOSIES: (Circle all that apply and add any that are not listed)

- | | | |
|----------------|--|-------------------|
| COPD/Emphysema | Joint Pains (Circle -shoulder, wrist, hands, knees, hips, ankles feet) | Insomnia |
| Asthma | Osteoporosis | Low Back Pain |
| Bronchitis | PAD/PVD | Neck Pain |
| Sinusitis | High Blood Pressure | Impotence |
| Liver Disease | Type I Diabetes | Prostate Problems |
| Hepatitis | Type II Diabetes | Cancer |
| Reflux | High Cholesterol or Triglycerides | Cataracts |
| Heartburn | Coronary Artery Disease | Glaucoma |
| Headaches | Heart Failure | Stomach ulcers |
| Strokes | Atrial Fibrillation | Kidney disease |
| Seizures | Heart Failure | Fractures |
| Dementia | Thyroid Disease | _____ |
| Neuropathy | Depression | _____ |
| Gout | Anxiety | _____ |
| Arthritis | | _____ |

SURGERIES: (Please provide the year of the surgery)

- | | | | |
|-------------|-----------------|---------------|-----------|
| Appendix | Heart bypass | Hips- R or L | Thyroid |
| Back | Heart Stents | Knees- R or L | Tonsils |
| Gallbladder | Hysterectomy | Neck | Vasectomy |
| | Ovaries Removed | | |

Other Surgeries: _____

If Yes, did you get sick while traveling or in the 2 months after traveling? Yes or No (Circle One)

FAMILY HISTORY: Please mark below any illnesses that **members** of your **family** have had. This **does not pertain to you**, but rather to your mother(**M**),father(**F**),children(**C**), brothers(**B**), sisters(**S**), aunts(**A**), uncles(**U**) and grandparents(**GP**) (on your side):

	Living	Deceased	Illnesses with Age of Onset	Cause of Death
Mother				
Father				
Children				
Sister/Brother				
Grandparents				
Aunts/Uncles				

Children #daughters _____ Significant illnesses? _____
 #sons _____ Significant illnesses? _____

Please **Circle** any of the following illnesses that your Mother/Father or Brothers/Sisters or Grandmother/Grandfather or Aunts/Uncles have had if not already mentioned above:

 check if none apply to your family

- Heart attack Open Heart Surgery(Bypass) Balloon Angioplasty/Stent in Heart Breast cancer
- Colon cancer Colon polyps Prostate cancer Melanoma skin cancer
- Ovarian cancer Uterine Cancer Kidney cancer Diabetes Aneurysm
- Stroke Alzheimer's Disease Osteoporosis Alcohol or Substance Abuse
- Mental Illness(Depression/Anxiety/Bipolar/Schizophrenia)

Please indicate by checking "YES" or "NO" which of the following symptoms **you** have had on a **significant or recurring** basis.

YES NO **checking here means any space left blank is a "no"**

- Yes No headaches If yes, new or old? Frequency of headaches is _____ per month?
- Yes No sinus problems with pain or pressure in forehead above eyes or in upper cheeks below eyes
- Yes No allergic symptoms of sneezing or daily runny nose
- Yes No allergic symptoms of nasal or sinus congestion

Please indicate by checking "YES" or "NO" which of the following symptoms **you** have had on a **significant or recurring** basis.

YES **NO** _____ checking here means any space left blank is a "no"

- Yes No allergic symptoms of watery or itching eyes
- Yes No double vision If yes, new or old?
- Yes No decrease in, total loss of, or change in vision in one or both eyes. If yes, ___temporary or ___permanent
- Yes No dry eyes If yes, use of artificial tears? Y N
- Yes No feels like something is in your eyes
- Yes No painful or painless mouth sores
- Yes No persistent hoarseness or changes in voice
- Yes No dry mouth daily
- Yes No jaw tiredness or pain with chewing
- Yes No dizziness If yes, is it more a spinning or lightheadedness? (circle one)
- Yes No decreased hearing If yes, for how long? _____ months/years
- Yes No ringing or noise in ears If yes, for how long? _____ months/years
- Yes No ear pressure or pain or drainage from ears
- Yes No loss of appetite
- Yes No difficulty with restful sleep
- Yes No snoring or stopping breathing during sleep
- Yes No shortness of breath at rest If yes, does it occur at night while you are laying down? __Y__N
- Yes No shortness of breath with exertion
- Yes No wheezing or asthma
- Yes No chest pain, tightness, or angina
- Yes No chest pain or discomfort when breathing or coughing
- Yes No leg swelling ___new ___increase in existing swelling
- Yes No cough If yes, do you cough anything up? _Y__N If yes circle - clear white yellow green
- Yes No coughing up blood
- Yes No difficulty swallowing If yes, is it mainly with solids, liquids, or both? (circle)
- Yes No pain with swallowing
- Yes No heartburn or acid reflux If yes, is it daily, weekly, or just on occasion? (circle)
- Yes No belly pain
- Yes No nausea
- Yes No vomiting

Please indicate by checking "YES" or "NO" which of the following symptoms **you** have had on a **significant or recurring** basis.

YES **NO** _____ checking here means any space left blank is a "no"

- Yes No diarrhea
- Yes No constipation
- Yes No rectal bleeding or blood in your stool
- Yes No tarry black stools
- Yes No jaundice (eyes/skin turn yellow)
- Yes No burning with urination
- Yes No difficulty getting your urine started
- Yes No increased frequency of urination If yes circle day or night?
- Yes No getting up at night to urinate. # times____
- Yes No need to urinate without much urine
- Yes No leaking urine leaking urine _____just with coughing or laughing____other times If yes, do you wear a pad?__Y__N
- Yes No pus or blood in your urine
- Yes No arthritis or pain in your joints: **knee** R L, **hip** R L, **shoulder** R L, **hands** R L, **elbows** R L, **other**

- Yes No history of foot pain
- Yes No skin rash. If, yes, where?_____
- Yes No new or changing moles. If, yes, where?_____
- Yes No skin nodules or bumps
- Yes No lack of sex drive
- Yes No depression or tearfulness
- Yes No insomnia or problems sleeping
- Yes No change in appetite
- Yes No anxiety or "nerves"
- Yes No passing out or fainting or loss of consciousness
- Yes No problems with memory loss
- Yes No confusion
- Yes No heat or cold intolerance. If yes, circle one or both
- Yes No unexplained hair loss
- Yes No falling episodes

Please indicate by checking "YES" or "NO" which of the following symptoms **you** have had on a **significant or recurring** basis.

YES **NO** _____ checking here means any space left blank is a "no"

Yes No been a victim of physical or emotional abuse. If yes, when did this last occur? _____

Yes No poor energy or fatigue

Yes No recent weight loss. If yes, have you been trying to lose wt? __Y__N

Yes No recent weight gain If yes, do you have any explanation as to why? _____

Yes No swollen or tender glands

Yes No back pain

Yes No aching pain in calves or thighs or hips with walking. If yes, how far can you walk without stopping due to the pain? _____

Yes No problems with night time muscle cramps

Yes No numbness or decreased sensation in your feet

Yes No problems with weakness or paralysis

Yes No problems with falls or poor coordination with walking or imbalance

Yes No history of easy bruising or bleeding

Yes No history of blood clots

Women only:

How many pregnancies have you had? _____

How many deliveries have you had? _____

How many miscarriages have you had? _____

How many abortions have you had? _____

What was your age when you started having periods? _____

What was your age when you had your first intercourse? _____

What number of sexual partners have you had? None <5 ≥ 5

Need for contraception? __ Y __ N Type Used: _____

Last Pap Smear? _____

Last Mammogram? _____

Yes No still having menstrual periods? If yes, when was your last period? ___wks./days ago.

Yes No Irregular periods or heavy periods or spotting between periods? (circle all appropriate)

Yes No Painful periods

Yes No If no longer having periods, any vaginal bleeding?

Yes No prior hysterectomy. If yes, was there cancer? __Yes__No. Were the ovaries removed

also?__Y__N

Yes No pain with intercourse ___check here if not sexually active in the last 3 years

Yes No vaginal discharge or itching or dryness (circle all appropriate)

Yes No breast lumps or nipple discharge (circle all appropriate)

Yes No hot flashes

Yes No regular breast self exams

Men only:

Yes No problems getting__ or maintaining__ an erection

Yes No breast lumps or nipple discharge

Yes No penile discharge

Yes No testicular lumps or mass

Yes No regular testicle exams

PREVENTIVE HEALTH:

Do you wear seat belts when you drive or ride in a car? Yes___ No__

Do you have a working smoke detector at home? Yes___ No__

When was your last eye exam by an eye doctor? ___within the last yr. ___within the last 2 yr.
___currently scheduled.

When was your last tetanus booster? Circle One within the last 5 year 5-10 years > 10 years

Have you had a prior pneumonia shot? If so, when?_____

How many 8oz. (can of pop is 12oz.) glasses of milk do you drink each day?_____

Do you take calcium supplements? **Yes** or **No** If yes how many each day? _____ How many mg. per pill?_____

Please Circle Any of the following tests that have been done in the last 10 years:

Echo	EKG	Stress Test	Heart Cath	Chest XRay	Pulmonary Functions Tests	Cat Scan	MRI
	Colonoscopy		Upper GI or Endoscopy	Ultrasound	Cystoscopy	Kidney/IVP	
	Mammogram		Bone Density Test	Blood Tests			

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Hancock Health Network may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Hancock Health Network's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Hancock Health Network reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: HHN Privacy Officer at 156 W. Muskegon, Greenfield, IN 46140.

With my consent, Hancock Health Network may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Hancock Health Network may mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Hancock Health Network restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hancock Health Network's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, Hancock Health Network may decline to provide treatment to me.

Patient's Name

Date of Birth

Signature of Patient or Legal Guardian

Date

Print Name of Legal Guardian (if not Patient)