First Name: _____ Middle_____ Last_____ AKA_____ DOB_____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ Work # _____

Email address_____ SS # _____

**Preferred Method of Contact: ❑ Home ❑ Cell ❑ Work ❑ Email

**May we leave messages about appointments and results? (Check all that apply) ❑ No ❑ Yes

❑ Home ❑ Cell ❑ Work

Gender: ❑ M ❑ F Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

Race/Ethnicity: _____ Primary Language: _____

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Minor Patients: Child lives with: _____ Contact #:_____

Mother/Guardian:_____ Contact #:_____

Father/Guardian: _____ Contact #: _____

Responsible Party, if different than above

Name: _____ Relationship to Patient: _____

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship: _____

ID/ SS#:_____ Group #: _____

Secondary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship: _____

ID/SS#: _____ Group #: _____

Is today's visit related to an accident? ❑ No ❑ Yes Date of Accident _____

OhioHealth

PATIENT IDENTIFICATION LABEL

REGISTRATION FORM

If work related, please complete the following questions:

Employer: _____ Address: _____ Phone #: _____

Date of Injury: _____ Claim #: _____

Allowed Diagnosis: _____

MCO: _____ Phone#: _____

Case Manager: _____ Phone#: _____

Have you filed paperwork with your employer? ❑ No ❑ Yes

Do you have an attorney? ❑ No ❑ Yes

Name: _____ Phone#: _____

Many of our patients during their recovery may stay with family members, friends or at a rehabilitation or nursing facility. Please provide our office staff with information as to where you are currently staying so we are able to contact you.

I am staying with a: ❑ Relative ❑ Friend ❑ Rehabilitation Center ❑ Skilled Nursing Facility

Name of Relative/Friend/ Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have a Health Care Power of Attorney? ❑ No ❑ Yes

Name of POA: _____ Contact #: _____

(If yes, please provide a copy of the POA documents)

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Patient/Guardian Signature: _____ Date: _____ Time: _____

OHIOHEALTH CANCER & SURGICAL SPECIALISTS PATIENT MEDICAL QUESTIONNAIRE

PATIENT NAME:_____DOB:_____

Height: _____ Weight: _____

What is the main problem that brings you to our office?_____

_____

PRIOR TESTING: (Pertaining to this visit - Mammograms, MRI, CT ultrasounds, etc…….)

TYPE OF TEST	DATE PERFORMED	FACILITY PERFORMED

PAST MEDICAL HISTORY: Do you (or did you) have any of the following:

- ☐ Heart Disease
- ☐ Liver Disorder
- ☐ Kidney Disorder
- ☐ Lung Disorder
- ☐ High Cholesterol
- ☐ High Blood pressure
- ☐ Migraine
- ☐ Stroke/TIA
- ☐ Blood Transfusion
- ☐ AIDS/HIV
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Blood Clots
- ☐ Ulcers
- ☐ Cancer_____
- ☐ Psychiatric Disorder_____
- ☐ Substance Abuse_____
- ☐ Other_____

_____

_____

PAST SURGERIES:

YEAR	SURGERY OR ILLNESS	WHERE	SURGEON

MEDICATIONS:

NAME	DOSE	TIMES/DAY	DATE STARTED	DATED ENDED

ALLERGIES: Do you Have a Latex Allergy: ☐ Yes ☐ No

MEDICATION/FOOD	TYPE OF REACTION

SOCIAL HISTORY:

Tobacco: (Present/Past Use): ☐ Yes ☐ No Type: ☐ Cigarettes ☐ Smokeless

If yes, how many years?_____Packs/Day?_____if stopped when?_____

Alcohol: (Present/Past): ☐ Yes ☐ No If Yes, # years_____, Drinks/day/week/month?_____

Quit? _____if so When?_____

Caffeine: Amount per day?_____

FAMILY HISTORY:

- ☐ Heart Disease
- ☐ Liver Disorder
- ☐ High Blood Pressure
- ☐ Migraine
- ☐ Kidney Disorder
- ☐ Migraine
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Lung Disorder
- ☐ High cholesterol
- ☐ Blood Clots
- ☐ Blood Transfusions
- ☐ Ulcers
- ☐ Stroke/TIA's
- ☐ Psychiatric Disorder
- ☐ Substance Abuse
- ☐ Cancer
- ☐ Other:_____

Please complete below for any medical conditions indicated above:

Relationship	Age	Living Y/N	Medical Condition and/or Cause of Death

PATIENT PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS: Please indicate Yes (Y) or No (N) in each box.

PATIENT NAME:_____

GENERAL:
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Loss of Appetite
- ☐ Tired/Fatigued
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Sleep Disturbance

EYES:
- ☐ Past eye disorders
- ☐ Vision Change/Blurry
- ☐ Dry Eyes
- ☐ Discharge/Tears
- ☐ Light Sensitivity

EARS/NOSE/THROAT:
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ EarDischarge
- ☐ Ringing in ears
- ☐ Change in Voice
- ☐ Nasal Drip
- ☐ Nose Bleeds
- ☐ Sores in/around mouth
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Sore throat

CARDIOVASCULAR
- ☐ Chest pain/Pressure
- ☐ Irregular hearbeat
- ☐ Bluish color lip/nails
- ☐ Extremity swelling
- ☐ Fatigue
- ☐ Stress Test
- ☐ Fainting
- ☐ Light Headedness
- ☐ Leg cramps with exertion
- ☐ shortness of breath with exertion

LUNGS/RESPIRATORY
- ☐ Shortness of Breath
- ☐ Asthma/wheezing
- ☐ Oxygen use at Home
- ☐ Coughing
- ☐ Chest discomfort
- ☐ Coughing up blood
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Excessive sputum
- ☐ Excessive snoring

NEUROLOGIC:
- ☐ Headache
- ☐ Stroke/Seizures
- ☐ Sudden Weakness
- ☐ Suddness numbness
- ☐ Temporary blindness
- ☐ Facial drooping
- ☐ slurred speech
- ☐ Inability to speak
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Tremors/Shaking
- ☐ Difficulty concentrating

INTEGUMENTARY/SKIN
- ☐ Suspicious lesions
- ☐ Dryness of skin
- ☐ Poor wound healing
- ☐ Itching
- ☐ Changes in skin color
- ☐ Flushing
- ☐ Rash
- ☐ Skin Cancers_____
- ☐ Unusual hair distribution

MUSCULOSKELETAL:
- ☐ Muscle Cramps
- ☐ Joint Pain/Swelling
- ☐ Fluid on Joints
- ☐ Back Pain
- ☐ Stiffness
- ☐ Muscle Weakness
- ☐ Arthritis
- ☐ Gout
- ☐ Loss of Strength
- ☐ Muscle Aches

NEUROLOGICAL
- ☐ Balance issues
- ☐ Headaches
- ☐ Tremors
- ☐ Falling down
- ☐ Inability to speak
- ☐ Brief Paralysis
- ☐ Vision Changes
- ☐ Seizures
- ☐ Spinning sensations
- ☐ Coordination difficulty
- ☐ Tingling
- ☐ Numbness
- ☐ Weakness

ALLERGIES:
- ☐ Persistent Infections
- ☐ Hives/Rash
- ☐ Seasonal allergies
- ☐ HIV Exposure

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Abdominal swelling/bloating
- ☐ Stomach Ulcers
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Bowel Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black/tarry stools
- ☐ Bloody Stools
- ☐ Colonoscopy?
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Yellowing of skin
- ☐ Gas

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Depression
- ☐ Violent thoughts
- ☐ Visions/Sounds

GENITOURINARY:
- ☐ Lack of sexual drive
- ☐ Kidney Stones
- ☐ Trauma to Genital Area
- ☐ Sextually transmitted disease
- ☐ Infections
- ☐ Blood in Urine
- ☐ Burning/Discomfort with urination
- ☐ Leaking Urine
- ☐ Night urination
- ☐ Incomplete bladder emptying
- ☐ For Men:
  - ☐ Prostate Cancer
  - ☐ Testicular pain/swelling
  - ☐ Penile discharge or Pain
- ☐ For Women:
  - ☐ Foul smelling discharge
  - ☐ Ovarian/uterine Cancer
- ☐ Pelvic Pain
- ☐ Genital Sores
- ☐ Painful urination
- ☐ Urinary urgency
- ☐ Erectile Dysfunction
- ☐ Abnormal cycles

ENDOCRINE:
- ☐ Excessive Hunger
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive Urination
- ☐ Excessive thirst
- ☐ Weight Change

HEMATOLOGY:
- ☐ Enlarged Lymph Nodes
- ☐ Bleeding
- ☐ Skin Discoloration
- ☐ Abnormal Bruising
- ☐ Fevers, unknown cause

BREAST:
- ☐ Breast Mass (Rt or Lt)
- ☐ Nipple Discharge
- ☐ Breast pain
- ☐ Abnormal Mammogram
- ☐ Breast enlargement

By signing I attest that the above information is complete, accurate and answered to the best of my knowledge

Patient signature:_____ Date:_____

Reviewed by:

Clinical Staff: _____Date:_____

Physician Signature: _____Date:_____