OCANA MEDICAL CENTER

GENERAL INFORMATION

_____ _____ _____ _____
Patient Last Name | First Name | MI | DOB

(_____) _____ (_____) _____
Home # | Cell Phone #

_____
Home Address | City | State | Zip

SS# _____-_____-_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____
Employer

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ White ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to Answer

_____
Email Address

In addition to gaining access to the online health portal, I would like to receive occasional emails with information to help me better manage my health. ☐ Yes ☐ No

_____ _____
Primary Insurance Carrier | Policy ID

☐ HMO ☐ PPO ☐ POS ☐ Other _____ (_____) _____
(Type of Plan) | Insurance Carrier Phone #

_____ _____
Secondary Insurance Carrier | Policy ID

☐ HMO ☐ PPO ☐ POS ☐ Other _____ (_____) _____
(Type of Plan) | Insurance Carrier Phone #

IMPORTANT: In case of emergency, who would we contact?

_____ _____
Name | Relationship

_____ (_____) _____
Address (Street/City/ZIP) | Home Phone #

_____ (_____) _____
Cell Phone # | Work #

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give the clinic (DaVIta Medical Group) consent to perform medical treatment."

Patient/Guardian (Signature) _____ Date _____

Patient/Guardian (Print Name _____

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Patient Last Name: _____ First Name: _____ DOB: _____

The U.S. Department of Health and Human Services has included sexual orientation and gender identity in its data collection requirements. This information will assist providers with improving the health of their patient population by delivering patient-centered, culturally-competent care.

Birth Sex: ☐ Male ☐ Female ☐ Ambiguous
(Gender assigned on your original birth certificate)

Identify As: ☐ Male ☐ Female ☐ Male to Female ☐ Female to Male
(Current gender identity) ☐ Other ☐ Decline

Preferred Pronoun: ☐ Male ☐ Female ☐ Gender Neutral
(the pronoun or set of pronouns that you would like others to use when talking to or about you)

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unknown ☐ Other ☐ Decline
(The gender to which you are attracted)

PATIENT MEDICAL HISTORY

Date of Last Physical Exam: _____ Previous Provider Name: _____

Provider Address: _____

PAST HISTORY (Personal and Allergies): Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous Breakdown	☐	☐
Alcohol Overuse	☐	☐	Emphysema/COPD	☐	☐	Ostomies _____	☐	☐
Allergies	☐	☐	Falls	☐	☐	Paralysis	☐	☐
(other than medications)			Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Seizures	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐	Sexually		
Bleeding Disorder	☐	☐	Heart Attack/MI	☐	☐	Transmitted Diseases	☐	☐
Cancer	☐	☐	Other Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
location: _____			(CHF/CAD)			Sleep Disorder	☐	☐
Cardiac Arrhythmias	☐	☐	Hepatitis	☐	☐	Stomach Ulcers	☐	☐
Pacemaker: _____			High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Vascular Disease	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐			
Depression	☐	☐	Measles/Mumps	☐	☐			

PERSONAL HABITS:

1) Have you ever smoked? ☐ Yes ☐ No If yes, are you are regular smoker now? ☐ Yes ☐ No

   Have you used chewing tobacco? ☐ Yes ☐ No If yes, number of years _____ If no, when did you quit? _____

2) Do you regularly drink alcohol? ☐ Yes ☐ No If yes, how often _____

3) Have you ever used any of the following? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other

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Patient Last Name: _____ First Name: _____ DOB: _____

OPERATIONS: List and indicate approximate year.

_____

_____

_____

SERIOUS INJURIES: List injuries and give approximate dates.

_____

_____

_____

HOSPITALIZATIONS: (Other than operations)
List reasons and approximate dates

_____

_____

_____

DIAGNOSTIC TESTS/EXAMS:

Last Test/Exam	Date	Location/Provider
Eye Exam:		
Foot Exam:		

IMMUNIZATIONS: (Please give date) Hepatitis B _____ Flu _____ Polio _____

Typhoid _____ Smallpox _____ Tetanus _____ Pneumococcal _____ Chicken Pox _____

Family History	Circle Sex		If Living		If Deceased	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters	M	F				
	M	F				
	M	F				
Spouse	M	F				
Sons/Daughters	M	F				
	M	F				

Check if any blood relative has or had any of the following and enter their relationship:

	Yes	No	Relationship to you
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding Tendency	☐	☐	_____
Cancer	☐	☐	_____
Colitis	☐	☐	_____
Congenital Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Epilepsy	☐	☐	_____
Goiter	☐	☐	_____
Gout	☐	☐	_____
Hay Fever	☐	☐	_____
Heart Attack	☐	☐	_____
High Blood Pressure	☐	☐	_____
Intestinal Polyps	☐	☐	_____
Kidney Disease	☐	☐	_____
Leukemia	☐	☐	_____
Migraine	☐	☐	_____
Nervous Breakdown	☐	☐	_____
Rheumatic Fever	☐	☐	_____
Sickle Cell Anemia	☐	☐	_____
Stomach Ulcers	☐	☐	_____
Stroke	☐	☐	_____
Suicide	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

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Patient Last Name: _____ First Name: _____ DOB: _____

MEDICATIONS:

- ☐ Asthma Wheezing Medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or Similar Products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or Heart Medicine
- ☐ Hormones
- ☐ Insulin or Diabetic Pills
- ☐ Anemia Medications
- ☐ Laxatives
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach/Digestive Medicine
- ☐ Weight-Reducing Pills
- ☐ Blood Thinners or Coumadin
- ☐ Dilantin or Seizure Medications
- ☐ Water Pills or Diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/Barbiturates
- ☐ Vitamins
- ☐ Other Prescription or Over-the-Counter Drugs

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How Often?	When Started?

Are you allergic to any medications: ☐ Yes ☐ No If yes, please list medications and the reactions.

Medication	Reaction

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SOCIAL / LIFESTYLE HISTORY:		Primary Language: _____
Is there someone that lives in your residence?	☐ Yes ☐ No	If yes, please list name and relationship:
Type of Residence		☐ Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story ☐ Assisted Living Facility Facility Name _____ ☐ Other _____
Durable Medical Equipment	☐ Yes ☐ No	Wheelchair _____ Oxygen _____ Walker _____ Nebulizer _____ Cane _____ CPAP/BIPAP _____ Other _____
Can you afford medicines?	☐ Yes ☐ No	Potential Referral to Patient Assistance Program
Transportation provided by?		

NUTRITIONAL HISTORY:		
Current Weight: _____ Lbs	Current Height: _____ Ft _____ In	Weight Changes in the past 6 months? ☐ Yes ☐ No
Current Diet Plan:		

EXERCISE/ACTIVITY:	
Current Activity:	How Often:
Physical Limitations:	

ACTIVITIES OF DAILY LIVING:		
Do you require assistance to bathe or groom?	☐ Yes ☐ No	If yes, Explain: _____
Do you require assistance for your toilet needs?	☐ Yes ☐ No	If yes, Explain: _____
Do you require assistance to eat?	☐ Yes ☐ No	If yes, Explain: _____
Do you have hearing loss?	☐ Yes ☐ No	Do you wear hearing aids? ☐ Yes ☐ No Last hearing exam date: _____

Additional Comments and Notes: _____

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PREVENTIVE SERVICE HISTORY

Patient Last Name: _____ First Name: _____ DOB: _____

Preventive Services	Date Received	Findings and Recommendations
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening		☐ Hypercholesterolemia
Cholesterol	_____	☐ Hyperlipidemia
LDL	_____	☐ Other: _____
EKG	_____	EKG Results: _____
Colorectal Cancer Screening		
Flexible Sigmoidoscopy	_____	
Barium Enema	_____	
Colonoscopy (not high risk)	_____	
Fecal Occult Blood Test	_____	
Diabetes Screening		
HgA1c	_____	☐ Cataracts
Foot Exam	_____	☐ Other: _____
Eye Exam	_____	
Glaucoma Screening		☐ Glaucoma
PAP and Pelvic Examination		
Prostate Cancer Screening Digital Rectal Exam (DRE) Prostate Specific Antigen Test (PSA)		
Mammogram Screening Breast Self Exam Mammogram		

Declaration to Decline Life-Prolonging Procedure (Living Will)

__ I have made such a declaration
__ I have NOT made such a declaration

Health Care Surrogate

__ I have designated a Health Care Surrogate
__ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

__ I have appointed a Durable Power of Attorney for Health Care decisions.
__ I have NOT appointed a Durable Power of Attorney for Health Care decisions

Date Reviewed: _____ Provider Signature _____