OhioHealth

OhioHealth Women's Health Primary Care Physicians
Patient Chart Summary Intake Form (Adult)

Form Directions: Please provide the patient information requested below. Once you have completed the entire form, please return it to the OhioHealth Women's Health Primary Care Physicians office in person, by mail at 1020 Cricket Lane, Mansfield, Ohio 44906, or fax the form to (419) 526-8859. All forms must be submitted prior to your initial appointment.

SECTION 1: PATIENT DEMOGRAPHICS

Last Name: ____________ First Name: ____________ MI: ______

Maiden Name: ____________ Nickname: ____________

Check ✓ all that apply to the patient: ❑ homeless ❑ does not have address ❑ does not have phone ❑ lives in nursing facility

Mailing Address: ____________

City: ____________ State: ______ Zip Code: ______ County: ______

Residential Address: ____________ ❑ Same as Mailing Address

City: ____________ State: ______ Zip Code: ______ County: ______

Email: ____________

Primary Home Phone: (______)____________ Cell Phone: (______)____________

Social Security Number: ______ - ______ - ______ Date of Birth (MM/DD/YYYY): ____/____/______

Gender: ❑ Male ❑ Female Language: ____________ Marital Status: ____________

Religious Affiliation: ____________ Race: ____________ Ethnicity: ❑ Hispanic ❑ Not Hispanic

EMERGENCY CONTACT INFORMATION:

Last Name: ____________ First Name: ____________ MI: ______

Address: ____________

City: ____________ State: ______ Zip Code: ______ County: ______

Preferred Phone Number: (______)____________ Alternate Phone Number: (______)____________

Relationship to Patient: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: ______

PATIENT EMPLOYMENT:

Employer Name/Address: ____________

Status: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ ______ Work Phone Number: (______)____________

Address: ____________

City: ____________ State: ______ Zip Code: ______ County: ______

Retired Date (if applicable): ____________

PATIENT MEDICAL INFORMATION

Primary Care Provider Name (Family Physician): ____________ ❑ None

What are the primary reasons for the patient's visit to our office? ____________

____

Are you being referred to this office by another physician? Name: ____________

ADVANCED DIRECTIVES

Check (✓) any that apply. Please bring a copy of any advanced directive forms with you to your next appointment.

❑ None ❑ DNR (Do Not Resuscitate) ❑ Living Will ❑ Do Not Place on Life Support
❑ Healthcare Proxy ❑ Durable POA (Power of Attorney)

GUARDIAN OR RESPONSIBLE PERSON (OF A MINOR OR OTHER PERSON):

Relationship to Patient: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: ____________

Last Name: ______________________ First Name: ______________________ MI: ________

Employer Name/Address: ____

Gender: ❑ Male ❑ Female Social Security Number:_________ - _____ - _______ Date of Birth: _____/_____/_________

Address: ____

City: ______________________ State: ____________ Zip Code: __________ County: ______________

Preferred Phone Number: (_________)____________________ Alternate Phone Number: (_________)____________________

SECTION 2: PATIENT MEDICATIONS*

❑ Check (✓) this box if the patient takes no medications.

	Medication Name (brand or generic name)	**Medication Strength/Dosage** (example: 40 mg or 5 oz)	**Prescribed Medication Directions** (example: one pill daily by mouth at bedtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

**If additional space is needed for Medications, please attach a list to this form.*

SECTION 3: PATIENT ALLERGIES*

❑ Check (✓) this box if there are no known allergies.

	Specific Allergy Name or Type (medications and environmental)	**Bodily Reactions to the Allergy** (Itching, breathing, stomach issues, etc.)	**Allergy Severity** (mild, moderate, severe)	**Onset Date**
1				
2				
3				
4				
5				
6				
7				
8				

**If additional space is needed for Allergies, please attach a list to this form.*

SECTION 4: PATIENT PAST MEDICAL AND SURGICAL HISTORY*

Have you ever had any problems or surgery in any of the body areas below? Check (✓) Yes or No. If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eye	❑ Yes	❑ No	Ear	❑ Yes	❑ No	Nose/Throat	❑ Yes	❑ No
Lung	❑ Yes	❑ No	Bowel/Bladder	❑ Yes	❑ No	Liver	❑ Yes	❑ No
Kidney	❑ Yes	❑ No	Muscle/Bone	❑ Yes	❑ No	Skin	❑ Yes	❑ No
Neurological	❑ Yes	❑ No	Endocrine	❑ Yes	❑ No	Stomach	❑ Yes	❑ No
Heart	❑ Yes	❑ No	Bleeding/Clotting	❑ Yes	❑ No	Other – Not Listed	❑ Yes	❑ No

❑ Check (✓) this box if the patient has no relevant past medical and surgical history.

	Disease or Problem	**Date Diagnosed**	**Procedures, Surgeries, Tests, or Management of the Disease** (include outcome and dates)	**Additional Comments**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

If additional space is needed for Past Medical History, please attach a list to this form.

SECTION 5: PATIENT FAMILY MEDICAL HISTORY*

Have any of your family members (father, mother, sibling, children, or grandparents) ever had any problems or surgery in any of the body areas below? If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eye	❑ Yes	❑ No	Ear	❑ Yes	❑ No	Nose/Throat	❑ Yes	❑ No
Lung	❑ Yes	❑ No	Bowel/Bladder	❑ Yes	❑ No	Liver	❑ Yes	❑ No
Kidney	❑ Yes	❑ No	Muscle/Bone	❑ Yes	❑ No	Skin	❑ Yes	❑ No
Neurological	❑ Yes	❑ No	Endocrine	❑ Yes	❑ No	Stomach	❑ Yes	❑ No
Heart	❑ Yes	❑ No	Bleeding/Clotting	❑ Yes	❑ No	Other – Not Listed	❑ Yes	❑ No

❑ Check (✓) this box if the patient has no relevant family medical history.

	Diagnosis or Problem	**Family Member - Relation**	**Age of Onset**	**Age of Death**	**Additional Comments**
1					
2					
3					
4					
5					
6					
7					
8					

If additional space is needed for Family History, please attach a list to this form.

SECTION 6: PATIENT SOCIAL HISTORY

General Information

Primary Language: ______________________ Language Spoken at Home: ______________________

Hand Dominance (check ✓ one): ❑ Right ❑ Left ❑ Ambidextrous (both hands)

Highest Education Level Achieved: ❑ Elementary ❑ Middle School ❑ High School ❑ Associate Degree ❑ Bachelor Degree ❑ Master Degree ❑ Doctorate ❑ Other: __________

Where are you employed? ______________________ Occupation/Job: ______________________

Do you have employment restrictions or hazards? ______________________

Do you have any military experience? ❑ Yes ❑ No Military Type: ______________________

Marital and Living Status

Current Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Legally Separated ❑ Polygamous ❑ Other ____

Have you ever been widowed? ❑ Yes ❑ No Have you ever been divorced? ❑ Yes ❑ No

Who do you live with? (Check ✓ all that apply) ❑ Husband ❑ Wife ❑ Children ❑ Siblings ❑ Parents ❑ Other: ______

Tobacco, Alcohol, and Caffeine Use

Tobacco Use (check ✓ one): ❑ Current ❑ Former ❑ Never ❑ Unknown

Type of Tobacco Use: ______________ Units/Packs per Day: ________ Years Used: ________

Have you ever tried to quit smoking? (Check ✓ one): ❑ Yes ❑ No

Year Quit: __________ Longest Timeframe Tobacco Free: ______________ Relapse Year: ________

If you have tried to quit smoking, what did you do to help you quit? ______________________

Are you exposed to passive smoke exposure? (Check ✓ one): ❑ Yes ❑ No

Are you an alcohol drinker? (Check ✓ one): ❑ Yes ❑ No

Types of Alcohol: ______________________ Frequency/Amount: ______________________

Do you use caffeine? (Check ✓ one): ❑ Yes ❑ No

Caffeine Type(s): ❑ Coffee ❑ Chocolate ❑ Energy Drink ❑ Tea ❑ Other Amount of caffeine per day: __________

Activity Level and Diet

Daily Activity Level (check ✓ one): ❑ Moderate ❑ Sedentary ❑ Vigorous

What type(s) of exercise do you do? ______________________

Number of times exercise per week: ______________ Number of hours exercise per week: ______________

Type of Diet (check ✓ all apply): ❑ 1600 calorie ❑ 1800 calorie ❑ 2000 calorie ❑ Diabetic ❑ Gluten free ❑ Healthy ❑ High calorie ❑ High fat ❑ High roughage ❑ High salt ❑ Junk food ❑ Low fat ❑ Low residue ❑ Low salt ❑ No red meat ❑ Vegan ❑ Vegetarian

Do you wear your seatbelt when you or other people drive? ❑ Yes ❑ No

SECTION 7: PATIENT PREFERRED PHARMACY

(#1) Pharmacy Name: ______________________ Location/City: ______________________

(#2) Pharmacy Name: ______________________ Location/City: ______________________

FOR OFFICE USE ONLY **Date Received:** ______________________

Chart Abstracted by: ______________________ Date Abstracted: ______________________