Name: ______________________ DOB___/___/___ Account No: __________________ Date: ___/___/___

What problems are you here for today:	Please list **ALLERGIES** to Medications (Reaction)
First date of symptoms/injury:	

Past Medical History: Please check "yes" if you have been treated for any of the following:

	YES	NO		YES	NO
Diabetes			Stomach/Intestine Problems		
High Blood Pressure			Allergy Problems		
Thyroid Problems			Kidney Problems		
Heart Disease/Cholesterol Prob			Neurological Problems		
Respiratory Problems			Cancer		
Bleeding Disorder			HIV/AIDS		
Heart Attack			Hepatitis		
Stroke			Other:		

Height: __________ **Weight:** __________ **Age:** __________

Past Surgical History: Please list **ALL** surgical procedures:

Current Medications: Please list **ALL** medications, amounts and times per day:

Social History: Please describe

Tobacco Use:	How much:	How long:
Alcohol Use:	How many per day:	How long:
Recreational Drug Use:	What type:	How long:
Occupation:		
Is this injury **work related**? **Motor vehicle related**?		

Family History:

	YES	NO	Describe:
Heart problems/Heart Attack/Murmur			
Diabetes			
Cancer			
Bleeding Disorder/Blood Clots			
Anesthesia Problems			
Other			

Name: ______________________ DOB___/___/___ Account No: __________________ Date: ___/___/___

Review of Systems: Please check "YES" or "NO" if you **currently** have these symptoms

		YES	NO		YES	NO		YES	NO
General	Fever/Chills sweats			Weight loss or gain Swollen glands			Excessive thirst/hunger Fatigue		
Neuro	Headache Dizziness			Passing out Visual disturbances Lightheadedness			Weakness Numbness, tingling		
Allergy	sneezing			Environmental allergy			Coughing		
Eyes	Vision changes			Watery/itchy eyes			Eye pain/pressure		
ENT	Hearing loss Hoarseness Throat pain			Ear noises Sinus pressure/pain Ringing in ears			Nasal congestion Snoring/sleep apnea Throat clearing		
Respira- tory	Cough Wheezing			Coughing up blood Difficulty breathing			Wake w/shortness of breath Shortness of Breath		
Cardiac	Chest pain Ankle swelling			Palpitations Easy bruising			Irregular heartbeat Bleeding disorder		
GI	Heartburn			Difficulty swallowing Nausea/vomiting			Abdominal pain Bowel irregularity/bleeding		
GU	Blood in urine			Frequent urination			Painful urination Prostate problems		
HEM LYMPH	Easy bruising			Swollen glands Sweating at night			Bleeding problems Feel warmer/colder than others		
Musculo skeletal	Joint aches Weakness in extremities			Muscle/bone aches Numbness/tingling in extremities			Stiffness Discoloration/change of temperature in extremities		
Skin	Rash Itching			Change in moles hives			Change in skin color/texture Hair changes		
Psych	Anxiety/panic			Depression			Excessive worry		

Would you like more information on:

Treatment for Migraines:

Cosmetic Enhancement Products: Latisse ☐ Botox ☐ Juvederm☐ Voluma ☐ Bellafil ☐

For special offers, please provide an email address:____

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr Robert Unsell, MD has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Print Name of Patient	Print Name of Parent or Guardian

Dated:________________________