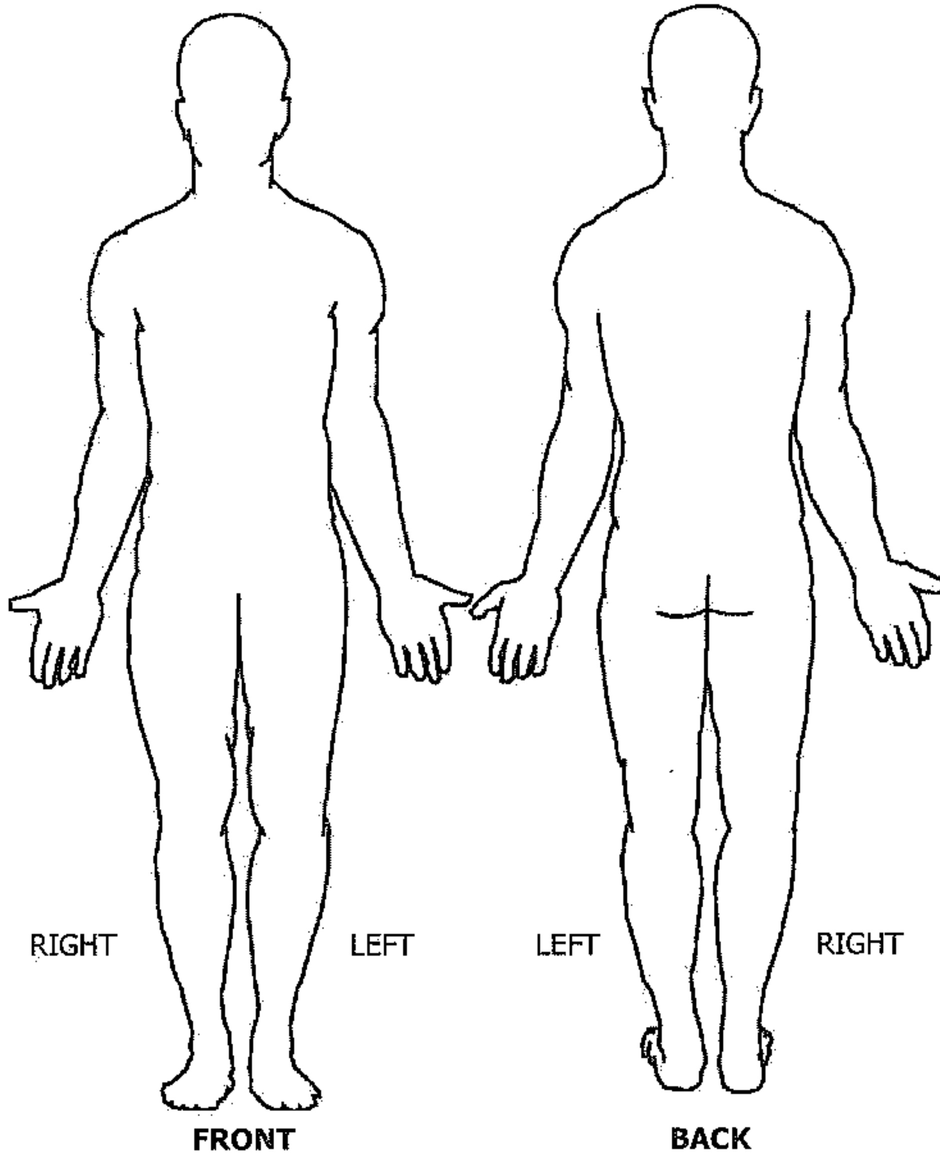
Patient Name: ______________________________ DOB: ________________ Date: ________________

Using the symbols below, please mark the areas where you feel the following sensations.

PLEASE PAY ATTENTION TO LEFT AND RIGHT SIDES.

Ache ^^^^^^^^^^ Numbness OOOOOOO Pins & Needles ======== Burning XXXXXXXX Stabbing ///////



Have you had and previous injury(s) to the body part(s) we are seeing you for today? ___ Yes ___ No

I attest that the information stated on this document is true and correct to the best of my knowledge and agree to contact and inform Dr. Nees/OSSO of any changes to the information stated herein.

X ____

Signature of patient or legal guardian (if not patient, please list your relationship to patient).

Personal / Family History

Please answer every question

Patient's Last Name ______________________ Patient's First Name______________________

Patient's Date of Birth ______________________ Date ______________________

Which hand is dominant? ☐ Ambidextrous ☐ Left ☐ Right

YOUR MEDICAL HISTORY

Please indicate if you have a history of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Blood Clots
- ☐ Chest Pain
- ☐ Chronic UTI
- ☐ Depression
- ☐ Ear, Nose, Throat Disorder
- ☐ Eye/Vision Problems
- ☐ Gout
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Problems
- ☐ MRSA Balance Problems
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Tuberculosis (TB)
- ☐ Other ______________
- ☐ Alzheimer's Disease
- ☐ Bronchitis
- ☐ Chemotherapy
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibrocystic Disease
- ☐ Head Injury
- ☐ Hepatitis
- ☐ Immune System Disorder
- ☐ Jaundice
- ☐ Kidney Stones
- ☐ Neurologic Disease
- ☐ Peripheral Vascular Disease
- ☐ Radiation
- ☐ Seizure
- ☐ Sleep Apnea
- ☐ Do you have a Cardiologist? (*Whom*) ______________________
  First and last name
  ____
  Location (if more than one)
- ☐ NONE
- ☐ Bleeding Problems
- ☐ Cancer (*Type*)______________
- ☐ Chronic / Past GI Disorders
- ☐ COPD
- ☐ Dialysis
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Insulin Dependent
- ☐ Kidney Failure
- ☐ Lupus/SLE
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Reflux Esophagitis
- ☐ Skin Disorders
- ☐ Stroke

FAMILY HISTORY

Please indicate if <u>YOUR FAMILY</u> has history of the following:

<u>(Only include parents, maternal or fraternal grandparents, siblings and children)</u>

- ☐ FAMILY HISTORY UNKNOWN
- ☐ Cancer______________
- ☐ Heart attack______________
- ☐ Osteoporosis______________
- ☐ Sickle cell trait/disease______________
- ☐ Other______________
- ☐ Ankylosing spondylitis______________
- ☐ Diabetes______________
- ☐ Heart disease______________
- ☐ Osteoarthritis______________
- ☐ Sjogren's Syndrome______________
- ☐ NONE
- ☐ Blood clots______________
- ☐ Lupus______________
- ☐ High blood pressure______________
- ☐ Rheumatoid arthritis______________
- ☐ Thyroid disease______________

SOCIAL HISTORY

If female, are you pregnant? ☐ Maybe ☐ Yes ☐ No

Have you had the pneumococcal vaccine? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

TOBACCO

Status: ☐ Currently (every day) ☐ Current (some days) ☐ Former ☐ Never

Type: ☐ cigarette ☐ eCig ☐ pipe ☐ cigar ☐ smokeless: snuff / chew

ALCOHOL

Status: ☐ Yes ☐ No ☐ Never

How often: ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

SUBSTANCE USE

Status: ☐ Yes ☐ No ☐ Never

Type:______________

PHYSICAL ACTIVITY

(walking, running, jogging, dancing, swimming, biking, aerobics, cross fit, yoga, etc.)

☐ Never ☐ 1 day ☐ 2 day ☐ 3 day ☐ 4 day ☐ 5 day ☐ 6 day ☐ 7 day

Patient's Last Name ______________________ Patient's First Name ______________________

Patient's Date of Birth ______________________ Date ______________________

SURGERIES

Please indicate if you have had any of the following surgeries: *(Write date of surgery on the line.)*

❑ **I have had NO SURGERIES**

❑ Appendectomy ______________________
❑ Cardiac Bypass ______________________
❑ Cataracts ______________________
❑ Heart Valve Implant ______________________
❑ Hip Replacement ❑ left ❑ right ______________________
❑ Implanted Defibrillator ______________________
❑ Knee Surgery ❑ left ❑ right ______________________
❑ Neck Surgery ______________________
❑ Shoulder ❑ left ❑ right ______________________
❑ Other: ______________________

❑ Back Surgery ______________________
❑ Cardiac Stent ______________________
❑ Gallbladder ______________________
❑ Hernia ______________________
❑ Hysterectomy *(females only)* ______________________
❑ Kidney or/other Transplant ______________________
❑ Knee Replacement ❑ left ❑ right ______________________
❑ Pacemaker ______________________
❑ Tonsillectomy ______________________

Have you ever had an adverse reaction/problem with anesthesia? ❑ Yes ❑ No

If yes, please explain: ______________________

Have you had blood relatives with anesthesia problems? ❑ Yes ❑ No

If yes, please explain: ______________________

REVIEW OF SYSTEMS

Please check all the symptoms you are currently experiencing. If NO symptoms, please check NONE.

GENERAL
❑ Chills ❑ Sweating ❑ Fatigue ❑ Fever
❑ Unexpected weight change ❑ NONE

HENT
❑ Congestion ❑ Dental problems ❑ Hearing loss ❑ Nose bleeds
❑ Runny Nose ❑ Sinus pain ❑ Sinus pressure ❑ Ringing in ears
❑ Trouble swallowing ❑ NONE

RESPIRATORY
❑ Apnea ❑ Chest tightness ❑ Cough ❑ Shortness of breath
❑ Wheezing ❑ NONE

CARDIOVASCULAR
❑ Chest pain ❑ Leg swelling ❑ Palpitations ❑ NONE

GASTROINTESTINAL
❑ Bloating/swelling ❑ Abdominal pain ❑ Anal bleeding ❑ Blood in stool ❑ Constipation
❑ Diarrhea ❑ Nausea ❑ Rectal pain ❑ Vomiting ❑ NONE

ENDOCRINE
❑ Cold intolerance ❑ Heat intolerance ❑ Excessive thirst ❑ Excessive hunger ❑ Frequent urination
❑ NONE

GENITOURINARY
❑ Difficulty urinating ❑ Painful urination ❑ Bedwetting ❑ Flank pain ❑ Frequent urination
❑ Genital sore ❑ Blood in urine ❑ Urgent urination ❑ Decreased urination ❑ NONE

MUSCULOSKELETAL
❑ Joint pain ❑ Back pain ❑ Joint swelling ❑ Muscle pain ❑ Neck pain
❑ NONE

SKIN
❑ Color change ❑ Paleness ❑ Rash ❑ Wound ❑ NONE

NEUROLOGICAL
❑ Dizziness ❑ Headaches ❑ Light-headedness ❑ Numbness ❑ Seizures
❑ Loss of consciousness ❑ Tremors ❑ Weakness ❑ NONE

HEMATOLOGIC
❑ Enlarged lymph nodes ❑ Bruises/bleeds easily ❑ NONE

PSYCHIATRIC
❑ Agitation ❑ Behavior problems ❑ Confusion ❑ Decreased concentration
❑ Hallucinations ❑ Nervous/anxious ❑ Self-injury ❑ Suicidal ideas ❑ NONE

OSSO

AN HPI AFFILIATE

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MEDICATION AND ALLERGY INFORMATION

Patient Name:____

ALLERGIES:____

☐ **SEE ATTACHED LIST**

MEDICATION	STRENGTH & FREQUENCY

Print Name: ______________________ Date of Birth: ______________

New State Law Regarding Narcotic Prescriptions
House Bill 2931
Effective January 1, 2020

Due to a new State of Oklahoma law, all narcotic medications **MUST** be sent to pharmacies in electronic form **ONLY.** Written narcotic scripts are no longer acceptable under this new law.

If you need a refill, you will be required to contact our office 48-72 hours in advance since our physicians are not always in the clinic setting. Same-day or next day refills **cannot** be guaranteed.

This is the only pharmacy we will use for your medications.

Pharmacy Name: ____

Pharmacy Address / Major Cross Street(s): ________________________

____

Pharmacy Phone Number: ________________________________

Confirm the above information is correct.
As this is where you will be required to pick up your prescription.

Patient Signature: ________________________ Date: ______________