Bates County Memorial Hospital

Family Care Clinics

of Bates County Memorial Hospital

Please fill out as many questions as you can. Date_____

Patient Information

Name_____ Date of Birth_____Age_____

Social Security Number_____

Address_____

Phone number_____ Cell phone number_____

E-mail address_____

Other Physician/Specialist you see **Other Physician/Specialist you see**

Name_____ **Name_____**

Specialty_____ **Specialty_____**

Phone number_____ **Phone number_____**

Fax number_____ **Fax number_____**

Chief complaint (briefly explain why you are here today)

Current medications- please list all medications from all doctors –Use back if out of space.

Medication	Dose(mg, cc's, etc)	How often	Prescribed by	Taken since?

Do you need any refills today? If so which medicine? Please list name and dose_____

_____

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Do you take any over the counter drugs? Include all vitamins and dietary supplements.

_____

_____

Do you have any allergies to medications? If so please list them and the reaction they cause.

_____ _____

_____ _____

Do you have any of the following problems?

Change in appetite __yes __no
Weight loss __yes __no
Weight gain __yes __no
Unable to sleep __yes __no
Excessive sleepiness __yes __no
Snoring __yes __no
Fatigue __yes __no
Fever __yes __no

Skin

Skin breakdown __yes __no
Skin rash __yes __no

Ears, Nose, Mouth, and Throat

Hearing loss __yes __no
Trouble breathing through nose __ yes __no
Headaches __yes __no

Urinary

Increased frequency __yes __no
Incontinent of urine __yes __no
Frequent infection __yes __no

Cardiovascular

Chest pain __yes __no
Circulation problems __yes __no
Short of breath __yes __no
Thyroid disease __yes __no
Valve replacement __yes __no
High blood pressure __yes __no

Hematologic/Endocrine

Blood disorder __yes __no
Diabetes __yes __no
Other disorders __yes __no

Musculoskeletal

low back pain __yes __no
neck pain __yes __no
joint pain or Swelling. __yes __no

Gastrointestinal

Abdominal pain __yes __no
Constipation __yes __no
Diarrhea __yes __no
Acid Reflux __yes __no
Vomiting __yes __no

Respiratory

Asthma __yes __no
Chronic cough __yes __no

Psychiatric

Anxiety __yes __no
Depression __ yes __no
Attention Deficit __yes __no

Neurologic

Memory problems __yes __no
Difficulty swallowing __yes __no
Dizziness __yes __no

Social History

Who do you live with?_____
Guardian name _____

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Are you _____Male _____Female
Highest level of education_____grade school___high school
____vocational school ___college ___graduate school
Where do you work_____
Do you have children?___yes ___no
Do they live with you?___yes ___no
Do you smoke? ___yes ___no
Chew tobacco? ___yes ___no
How many years? _____

Past medical history

Have you ever had surgery? If so, what kind and what year?

_____

_____

_____

_____

_____

Emergency contact information

Name_____ Name_____
Phone number_____ Phone number_____
Cell number _____ Cell number _____
Relationship _____ Relationship _____
Do we have permission to disclose your health information To this person? ___yes ___no___ Please initial_____

Do we have permission to disclose your health information to this person?___yes ___no Please initial_____

Phone Authorizations: You hereby grant permission and consent to us, our assignees, and third party collection agencies: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and include in any such message information required by law (including debt collection laws) and/or regarding amounts owed by you; (3) to send you text messages or emails using any email addresses you provide; (4) to use pre-recorded/artificial voices messages and/or an automatic dialing device (an "autodialer") in connection with any communications made to you or related to your account.

FINANCIAL ASSISTANCE: I understand that BCMH has a financial assistance policy for which I may qualify. The income guidelines are based on Federal Poverty Limits. I understand that if my income is less than the guideline for my family size, I may qualify for assistance. I have been offered the Financial Assistance Summary. ___Accepted ___Declined

Signature:_____ Date:_____

Please present this form along with insurance cards to front desk when completed.

Thanks for choosing us for your health care needs!