PATIENT INFORMATION

WCCHS
Wyoming County Community Health System
400 N. Main Street Warsaw, NY 14569

Provider you are seeing today?_____ Referred by_____

Private Physician/NP/PA_____

Patient's Name_____ DOB___/___/_____ Age_____ Sex: M F

Height_____Weight_____ SS#_____ Marital Status_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email Address_____

Patient's Employer_____ Employer's Address_____

Occupation_____ Phone_____ Length of Employment_____

Spouse/Parent Name_____ DOB___/___/___ SS#_____ Occupation_____

Spouse/Parent's Employer_____ Phone_____ Length of Employment_____

Emergency Contact_____ Relationship_____ Phone_____

Primary Health Insurance_____ ID#_____ Group#_____

Policyholder's Name_____ DOB___/___/_____ SS#_____

Employer_____

Secondary Health Insurance_____ ID#_____ Group#_____

Policyholder's Name_____ DOB___/___/_____ SS#_____

Employer_____

Is another Insurance Primary to Medicare?_____ If yes what?_____

Is another Insurance Primary to Medicaid?_____ If yes what?_____

Were you injured on the job?_____ Injury date_____ WCB#_____ Carrier Case#_____

Insurance Carrier for Employer_____

Address_____ Work Status_____

Were you injured in an accident?_____ Auto?_____ Liability?_____ Date_____

Claim or Policy #_____ Work Status_____

Name and Address of Insurance Company_____

_____

I hereby give my consent to WCCHS SPORTS MEDICINE to use and disclose protected health information about me to carry out treatment, payment, and health care operations, and I authorize payment of medical benefits to the named provider/practice for services rendered. If professional collections are necessary, I understand I will incur additional fees as the patient or guardian.

Signature of Patient or Guardian_____ Date_____

Printed Name of Patient or Guardian_____

MEDICAL HISTORY

Patient's Name_____ Date_____

Reason for Visit_____ Duration_____

If Injury or Accident, give History_____

Allergies: List all allergies to medications or other items, and the nature of the reaction.

ALLERGY	REACTION	ALLERGY	REACTION

Medications: List all medications currently taking

DRUG	STRENGTH	DOSE (How often)

Surgery: List all operations, in-patient or ambulatory.

Any Anesthesia Complications_____

OPERATION	YEAR	OPERATION	YEAR

Using any devices like a cane or walker, etc?_____

Conditions you have or had in the past: (if not listed, please describe_____)

❑ Aids	❑ Cancer	❑ Hepatitis	❑ Mononucleosis	❑ Suicide attempt
❑ Alcoholism	❑ Chemical dependency	❑Hernia	❑ Mumps	❑ Hypertension
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pacemaker	❑ Hyperthyroidism
❑ Anorexia	❑ Diabetes	❑ High cholesterol	❑ Pneumonia	❑ Tonsillitis
❑ Appendicitis	❑ Emphysema	❑ HIV Positive	❑ Polio	❑ Tuberculosis
❑ Arthritis	❑ Epilepsy	❑ Kidney disease	❑ Prostate problem	❑ Typhoid fever
❑ Asthma	❑ Glaucoma	❑ Liver disease	❑ Psychiatric problem	❑ Ulcers
❑ Bleeding disorder	❑ Goiter	❑ Measles	❑ Rheumatic Fever	❑ Vaginal infection
❑ Breast lump	❑ Gonorrhea	❑ Migraine headache	❑ Scarlet Fever	❑ Venereal disease
❑ Bronchitis	❑ Gout	❑ Miscarriage	❑ Sleep apnea	❑ GERD
❑ Bulimia	❑ Heart disease	❑ Multiple Sclerosis	❑ Stroke	

Symptoms you have or had in the past year: (if not listed, please describe_____)

General

❑ Chills
❑ Depression
❑ Dizziness
❑ Fainting
❑ Fever
❑ Forgetfulness
❑ Headache ❑ Flu symptoms
❑ Loss of sleep
❑ Loss of weight
❑ Nervousness
❑ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

❑ Arms ❑ Hips
❑ Back ❑ Legs
❑ Feet ❑ Neck
❑ Hands ❑ Shoulders

Skin

❑ Bruise easily
❑ Scarring ❑ Rash

Genitourinary

❑ Blood in urine ❑ Lack of control
❑ Frequent urination ❑ Painful urination

Gastrointestinal

❑ Poor appetite ❑ Gas
❑ Bloating ❑ Hemorrhoids
❑ Bowel changes ❑ Indigestion
❑ Constipation ❑ Nausea
❑ Diarrhea ❑ Rectal bleeding
❑ Excessive hunger ❑ Stomach pain
❑ Excessive thirst ❑ Vomiting

Eye, Ear, Nose and Throat

❑ Bleeding gums ❑ Vision problems
❑ Hoarseness ❑ Earache
❑ Loss of hearing ❑ Nosebleeds

Cardiovascular

❑ Chest pain
❑ High blood pressure
❑ Low blood pressure
❑ Irregular heartbeat
❑ Poor circulation
❑ Varicose veins

MEDICAL HISTORY Continued

Family History: List any Medical illnesses in each member.

Father_____

Mother_____

Brother(s)_____

Sister(s)_____

Grandparents_____

Children_____

List any other disease(s) which occur in your family, and the relationship to you_____

_____

Personal Habits

Do you currently use tobacco?_____ In the past?_____ Never_____ Type and amount_____

Do you currently use alcohol?_____ Type_____ Never_____ Weekly amount_____

Do you currently use drugs?_____ In the past?_____ Never_____ Type and amount_____

Diet History: Describe any special diets you follow.

_____

Exercise History: Describe what types of exercise you perform and how often.

_____

Educational History: List highest grade completed and degree received.

_____

Occupational History: Describe the current work you perform or may have performed in the past.

_____

Are you currently working? _____YES _____NO_____

Please include any questions or comments not already on this form.

_____

_____

_____

Signature of Patient or Guardian_____ Date_____

Reviewed by Provider _____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____