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 Wyoming County Community Hospital and its providers 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_____