UofL Physicians

PATIENT INFORMATION FORM

Patient Information Name ______________________ Also Known As ____________

SSN ____________ Date of Birth ____________ Sex ☐Male ☐Female

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Preferred Language____________

Special Needs ☐Adult Sitter/Guardian ☐Ambulates with Assistive Dev ☐Hearing Impaired ☐Sight Impaired ☐Multiple Birth ☐Speech Impaired ☐Wheelchair ☐Interpreter ☐Transportation Needs

Patient Race: Race – a human population considered distinct based on physical characteristics.

☐ American Indian ☐ Alaska Native
☐ Asian ☐ Black or African American
☐ White ☐ Native Hawaiian or Other Pacific Islander
☐ Other ☐ Declined

Ethnicity: Ethnicity a term which represents social groups with a shared history, sense of identity, geography and cultural roots which may occur despite racial difference.

☐Hispanic or Latino ☐ Not Hispanic or Latino

Religion ____________

Home Address______________________

City, St____________ County____________ Zip Code ____________

Home Phone ____________ Cell Phone____________ Work/Other Phone ____________

Employment Status ____________ Email ____________

Employer Name ____________ Employer Phone Number ____________

Employer Address______________________

Employer City, St ____________ Zip Code____________

Primary Physician ____________ Primary Physician Phone ____________

Referring Physician ____________ Referring Physician Phone ____________

Preferred Pharmacy____________ Pharmacy Phone ____________

Pharmacy Address, City, St, Zip ____________

Parent/Guardian(s) or Spouse Information Name______________________

Relationship to Patient ____________ SSN ____________ Date of Birth ____________

Address (If Different) ____________ Zip Code____________

Employer ____________ Employer Phone Number ____________

Employer Address ____________ Zip Code____________

Home Phone ____________ Cell Phone ____________ Email ____________

UofL Physicians

Patient Name: ________________________________ Patient DOB ______________

Emergency Contact (someone other than a parent and who does not live with the patient or a parent)

Name ______________________ Relationship ______________ Phone ______________

Parent/Guardian #2 Name ____

Relationship to Patient ____________________ SSN ______________ Date of Birth __________

Address (If Different) ________________________________ Zip Code ______________

Employer ________________________________ Employer Phone Number ______________

Employer Address ________________________________ Zip Code ______________

Home Phone ______________ Cell Phone ______________ Email ______________

Medical Insurance Info.	Primary Insurance	Secondary Insurance
Subscriber ID		
Group or Plan Number		
Plan/Program Code		
Insurance Co. Name		
Insurance Co. Phone Number		
Patient Relation to Subscriber		
Subscriber Name		
Subscriber Street Address		
Subscriber City and State		
Subscriber Zip Code		
Subscriber Date of Birth		
Subscriber Sex		
Subscriber Social Security #		
Subscriber Employer		
Co-pay Amount		

Injury Related Information ☐ Work Related ☐ Auto ☐ Motorcycle ☐ Other Date & Time of Injury ______________

State Where Injury Occurred ______________ Contact Name ______________ Phone ______________

Claim # ______________________ Insurance Co. ______________________

Insurance Co. Address, City, St, Zip ____

____ ______________

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name ______________________

GENERAL CONSENT FORM

PATIENT NAME: ______________________________ Date of Birth: ________________

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims.
Initials: ________

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions.
Initials: ________

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient. Initials: ________

Cell Phone Calls. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities_____ Declined_____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices_____ Declined_____

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only_____ Declined_____

____ ____________________

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature **Date**

If Parent/Legal Guardian/Legal Authorized Representative, Print Name ____________________________

UofL Physicians
INTERNAL MEDICINE

Centers for Primary Care
Internal Medicine Group
UofL HealthCare Outpatient Center, Suite 370
401 East Chestnut Street, Louisville, KY 40202
PH: 502.588.4500 Fax: 502.588.4501

New/Interval Physical Visit

Name: ______________________ DOB: ______________ DATE: ______________

Personal Medical History

Check all that apply. Use Comment area for additional details or other disorders

Abnormal EKG
Abnormal Mammogram
Allergies (seasonal/environment)
Arthritis
Asthma
Anemia
Anxiety
Back Pain
BCG (TB immunization)
Bladder Stones
Brain Hemorrhages
Brain Surgery
Broken Bones
Bronchitis
Breast Cancer
Cataracts
Chest Pain
Chrons Disease
Colon Cancer
Colitities
Concussions
Constipation
Depression
Deep Vein Thrombosis/Blood Clots
Dental Problems
Diabetes (juvenile; Type 1)
Diabetes (adult; Type 2)
Diverticulosis/Diverticulitis
Diarrhea (chronic)
Emphysema (COPD)
Family History of Tuberculosis (TB)
Falling
Gallbladder Problems/Stones
Glaucoma (pressure in the eye)
Gum Disease
Head Injury
Hearing Loss
Headaches (migraine)
Headaches (tension)
Headaches (tension)
Heart Attack
Heart Failure
Heart Murmurs
Hepatitis
HIV/AIDS
Hiatal (high) Hernia
High Cholesterol
High Blood Pressure
Kidney Stones
Leg Swelling
Liver Disease
Murmur (heart)
Pneumonia
Positive TB Skin Test
Rheumatic Fever
Seizures
Sinus Problems/Sinusitits
Stroke
Transfusions (blood)
Transient Ischemic Attack (TIA)
Thyroid (hypoactive; low)
Thyroid (hyperactive; high)
Ulcerative Colitis
Ulcers (stomach)
Ulcers (legs and feet)
Urinary Tract Infections

Other Conditions/Comments/Details:

Social/Occupational History

Marital Status: ❑ Single ❑ Married ❑ Divorced
❑ Living Together ❑ Separated ❑ Widowed

Number of Children? ______________

Ages? ______________

Who lives at home besides yourself? ______________

Do any family members have significant healthcare or emotional needs? ______________

How far did you go in school? ______________

Please list any hobbies or recreational activities? ______________

Employment: ❑ Retired
❑ Employed (❑ full-time ❑ part-time ❑ self-employed ❑ home maker)
❑ unemployed

Current Occupation: ______________

Previous Occupations: ______________

Have you had on the job exposure to any of the following:

❑ Asbestos
❑ Lead
❑ Dust Type: ______________
❑ Chemicals Type: ______________
❑ Solvents Type: ______________
❑ Radiation Type: ______________
❑ Other Specify: ______________

I have reviewed and confirmed this information: ______________DO/MD/ARNP Date: ______________

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New/Interval Physical Visit

Name: ______________________ DOB: ____________ Date: ____________

Health Maintenance

Please indicate whether you have had or received any of the following screening tests or immunizations and the date if known.

	Tests	Yes	No	Unsure	Date
Women Only	Breast Self Exams				
	Pap Smear				
	Mammogram				
	Rubella Blood Test (for child bearing years only)				
Men And Women	Cholesterol or Lipid Profile				
	Colonoscopy				
	Sigmoidoscopy				
	Stool Blood Test				
Men Only	Prostate Cancer Test (PSA; Prostate Specific Antigen)				
	Immunizations	**Yes**	**No**	**Unsure**	**Date**
Men And Women	Hepatitis A Vaccine				
	Hepatitis B Vaccine				
	Influenza Vaccine				
	Measles/Mumps/Rubella (MMR)				
	Pneumonia Vaccine (Pneumovax)				
	Tetanus Booster				
	Tuberculosis Skin Test (PPD; TB Skin Test)				
	Other (describe)				
	Other (describe)				

Family Medical History

Please indicate if any blood relative has ever had any of the following. Check box and indicate which relative(s):

Yes No
- ❑ ❑ Kidney Disease ____________
- ❑ ❑ Bleeding Problems ____________
- ❑ ❑ Breast Cancer ____________
- ❑ ❑ Colon Cancer ____________
- ❑ ❑ Diabetes ____________
- ❑ ❑ Migraine Headaches ____________
- ❑ ❑ Heart Attacks ____________
- ❑ ❑ High Blood Pressure ____________
- ❑ ❑ Stroke ____________
- ❑ ❑ Tuberculosis ____________
- ❑ ❑ Liver Disease ____________
- ❑ ❑ Other ____________

Please indicate the ages and whether living or dead for each of the following:

Family Member	Age	Living/Deceased
Mother		
Father		
Brother/Sister		
Brother/Sister		
Brother/Sister		
Brother/Sister		

Other: ____

I have reviewed and confirmed this information: ____________ DO/MD/ARNP Date: ____________

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New/Interval Physical Visit

Name: ______________________ DOB: __________ Date: __________

Medical Allergies

Drug/Material	Reaction
❑ No known medical allergies	

Current Medications

List all medications that you currently are taking on a regular or as needed basis.
Also include any herbal, natural or other over the counter preparations.

Medication/Supplement	Dose (mg)	Times per day	Indication
❑ No medications, herbal preparations or supplements			

Preventative Health

Check all that apply.

Yes	No			
❑	❑	Do you smoke cigarettes?	Packs/day__________	Years__________
❑	❑	Do you smoke cigars?	#/day__________	Years__________
❑	❑	Do you use smokeless tobacco?	Type__________	Years__________
❑	❑	Do you smoke a pipe?	#/day__________	Years__________
❑	❑	Cups of coffee you drink daily?	__________ Tea? __________	Soft Drinks? __________
❑	❑	Do you drink alcoholic beverages?	Daily?_____ Weekends? _____	Occasionally _____
		Typical amount per day or week?	__________	
❑	❑	Used street drugs?	Type__________	Intravenous? ❑ Yes ❑ No
❑	❑	Abused prescription drugs?	Type __________	
❑	❑	Exercise Regularly?	Times/week__________	How long? __________
❑	❑	Smoke Detectors in your home?		
❑	❑	Do you wear your auto seatbelt?		
❑	❑	Do you have a living will?		
❑	❑	Designated a health care surrogate to make medical decisions for you?		
❑	❑	Have a power of attorney or guardian? Who? __________		

Comments/Details: ______________________________

____

____

I have reviewed and confirmed this information: ______________________ DO/MD/ARNP Date: __________

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Name: ______________________ DOB: ______________ Date: ______________

Women's Health

Obstetrical History

How many times have you been pregnant? ______________
How many children have you delivered? ______________
How many natural (vaginal) deliveries? ______________
How many C-sections? ______________
Your age at first delivery? ______________
Age at last delivery? ______________
Did you breast feed? ______________

Menstrual History

How old were you when your menstrual periods began? ______________
Are you still having menstrual periods? ______________
Are your/were your menstrual periods regular? ______________
How long do your menstrual periods last? ______________
How many days do your periods typically last? ______________
Do you use any of the following during your menstrual periods? ❑ tampons (_____/day) ❑ pads (_____/day)

Birth Control

How many lifetime sexual partners have you had? ______________
Have you had any new sexual partners within the last year? ______________

Current	Past	Method
		Condoms
		Contraceptive Foam
		Depoprovera Shot
		Pills
		Intrauterine Device
		Contraceptive Sponge
		Other (specify
Notes:		

Osteoporosis

Have you ever had a bone density (osteoporosis) screening test? ❑ Yes ❑ No ❑ Unsure
Have you had your ovaries removed? ❑ Yes ❑ No ❑ Unsure
Do you take estrogen (female hormones)? ❑ Yes ❑ No ❑ Unsure

I have reviewed and confirmed this information: ______________________ DO/MD/ARNP Date: ______________