OhioHealth Endocrinology Physicians
Patient Chart Summary Intake Form (Adults)

Form Directions: Please provide the patient information requested below. Once you have completed the entire form, please return it to the OhioHealth Endocrinology Physicians office in person, by mail at 295 Glessner Avenue, Mansfield, Ohio 44903, or fax the form to (419) 522-2240. All forms must be submitted prior to your next appointment.

SECTION 1: PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Maiden Name: _____ Nickname: _____

Check ✓ all that apply to the patient: ❑ homeless ❑ does not have address ❑ does not have phone ❑ lives in nursing facility

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Residential Address: _____ ❑ Same as Mailing Address

City: _____ State: _____ Zip Code: _____ County: _____

Email: _____

Primary Home Phone: (_____) _____ Cell Phone: (_____) _____

Social Security Number: _____ - _____ - _____ Date of Birth (MM/DD/YYYY): ____/____/____

Gender: ❑ Male ❑ Female Language: _____ Marital Status: _____

Religious Affiliation: _____ Race: _____ Ethnicity: ❑ Hispanic ❑ Not Hispanic

EMERGENCY CONTACT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Relationship to Patient: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: _____

PATIENT EMPLOYMENT:

Employer Name/Address: _____

Status: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ _____ Work Phone Number: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Retired Date (if applicable): _____

PATIENT MEDICAL INFORMATION

Primary Care Provider Name (Family Physician): _____ ❑ None

What are the primary reasons for the patient's visit to our office? _____

_____

Are you being referred to this office by another physician? Name: _____

ADVANCED DIRECTIVES

Check (✓) any that apply. Please bring a copy of any advanced directive forms with you to your next appointment.

❑ None ❑ DNR (Do Not Resuscitate) ❑ Living Will ❑ Do Not Place on Life Support
❑ Healthcare Proxy ❑ Durable POA (Power of Attorney)

GUARDIAN OR RESPONSIBLE PERSON (OF A MINOR OR OTHER PERSON):

Relationship to Patient: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: _____

Last Name: _____ First Name: _____ MI: _____

Employer Name/Address: _____

Gender: ❑ Male ❑ Female Social Security Number: _____ - ____ - _____ Date of Birth: ____/____/_____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

SECTION 2: PATIENT MEDICATIONS*

❑ Check (✓) this box if the patient takes no medications.

	Medication Name (brand or generic name)	**Medication Strength/Dosage** (example: 40 mg or 5 oz)	**Prescribed Medication Directions** (example: one pill daily by mouth at bedtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

**If additional space is needed for Medications, please attach a list to this form.*

SECTION 3: PATIENT ALLERGIES*

❑ Check (✓) this box if there are no known allergies.

	Specific Allergy Name or Type (medications and environmental)	**Bodily Reactions to the Allergy** (Itching, breathing, stomach issues, etc.)	**Allergy Severity** (mild, moderate, severe)	**Onset Date**
1				
2				
3				
4				
5				
6				
7				
8				

**If additional space is needed for Allergies, please attach a list to this form.*

SECTION 4: PATIENT PAST MEDICAL AND SURGICAL HISTORY*

Have you ever had any problems or surgery in any of the body areas below? Check (✓) Yes or No. If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eye	❑ Yes ❑ No	Ear	❑ Yes ❑ No	Nose/Throat	❑ Yes ❑ No
Lung	❑ Yes ❑ No	Bowel/Bladder	❑ Yes ❑ No	Liver	❑ Yes ❑ No
Kidney	❑ Yes ❑ No	Muscle/Bone	❑ Yes ❑ No	Skin	❑ Yes ❑ No
Neurological	❑ Yes ❑ No	Endocrine	❑ Yes ❑ No	Stomach	❑ Yes ❑ No
Heart	❑ Yes ❑ No	Bleeding/Clotting	❑ Yes ❑ No	Other – Not Listed	❑ Yes ❑ No

❑ Check (✓) this box if the patient has no relevant past medical and surgical history.

	Disease or Problem	Date Diagnosed	Procedures, Surgeries, Tests, or Management of the Disease (include outcome and dates)	Additional Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**If additional space is needed for Past Medical History, please attach a list to this form.*

SECTION 5: PATIENT FAMILY MEDICAL HISTORY*

Have any of your family members (father, mother, sibling, children, or grandparents) ever had any problems or surgery in any of the body areas below? If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eye	❑ Yes ❑ No	Ear	❑ Yes ❑ No	Nose/Throat	❑ Yes ❑ No
Lung	❑ Yes ❑ No	Bowel/Bladder	❑ Yes ❑ No	Liver	❑ Yes ❑ No
Kidney	❑ Yes ❑ No	Muscle/Bone	❑ Yes ❑ No	Skin	❑ Yes ❑ No
Neurological	❑ Yes ❑ No	Endocrine	❑ Yes ❑ No	Stomach	❑ Yes ❑ No
Heart	❑ Yes ❑ No	Bleeding/Clotting	❑ Yes ❑ No	Other – Not Listed	❑ Yes ❑ No

❑ Check (✓) this box if the patient has no relevant family medical history.

	Diagnosis or Problem	Family Member - Relation	Age of Onset	Age of Death	Additional Comments
1					
2					
3					
4					
5					
6					
7					
8					

**If additional space is needed for Family History, please attach a list to this form.*

SECTION 6: PATIENT SOCIAL HISTORY

General Information

Primary Language: _____ Language Spoken at Home: _____

Hand Dominance (check ✓ one): ❑ Right ❑ Left ❑ Ambidextrous (both hands)

Highest Education Level Achieved: ❑ Elementary ❑ Middle School ❑ High School ❑ Associate Degree ❑ Bachelor Degree ❑ Master Degree ❑ Doctorate ❑ Other: _____

Where are you employed? _____ Occupation/Job: _____

Do you have employment restrictions or hazards? _____

Do you have any military experience? ❑ Yes ❑ No Military Type: _____

Marital and Living Status

Current Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Legally Separated ❑ Polygamous ❑ Other ____

Have you ever been widowed? ❑ Yes ❑ No Have you ever been divorced? ❑ Yes ❑ No

Who do you live with? (Check ✓ all that apply) ❑ Husband ❑ Wife ❑ Children ❑ Siblings ❑ Parents ❑ Other: _____

Tobacco, Alcohol, and Caffeine Use

Tobacco Use (check ✓ one): ❑ Current ❑ Former ❑ Never ❑ Unknown

Type of Tobacco Use: _____ Units/Packs per Day: _____ Years Used: _____

Have you ever tried to quit smoking? (Check ✓ one): ❑ Yes ❑ No

Year Quit: _____ Longest Timeframe Tobacco Free: _____ Relapse Year: _____

If you have tried to quit smoking, what did you do to help you quit? _____

Are you exposed to passive smoke exposure? (Check ✓ one): ❑ Yes ❑ No

Are you an alcohol drinker? (Check ✓ one): ❑ Yes ❑ No

Types of Alcohol: _____ Frequency/Amount: _____

Do you use caffeine? (Check ✓ one): ❑ Yes ❑ No

Caffeine Type(s): ❑ Coffee ❑ Chocolate ❑ Energy Drink ❑ Tea ❑ Other Amount of caffeine per day: _____

Activity Level and Diet

Daily Activity Level (check ✓ one): ❑ Moderate ❑ Sedentary ❑ Vigorous

What type(s) of exercise do you do? _____

Number of times exercise per week: _____ Number of hours exercise per week: _____

Type of Diet (check ✓ all apply): ❑ 1600 calorie ❑ 1800 calorie ❑ 2000 calorie ❑ Diabetic ❑ Gluten free ❑ Healthy ❑ High calorie ❑ High fat ❑ High roughage ❑ High salt ❑ Junk food ❑ Low fat ❑ Low residue ❑ Low salt ❑ No red meat ❑ Vegan ❑ Vegetarian

Do you wear your seatbelt when you or other people drive? ❑ Yes ❑ No

SECTION 7: PATIENT PREFERRED PHARMACY

(#1) Pharmacy Name: _____ Location/City: _____

(#2) Pharmacy Name: _____ Location/City: _____

FOR OFFICE USE ONLY **Date Received:** _____

Chart Abstracted by: _____ Date Abstracted: _____