MID-AMERICA SARCOMA INSTITUTE, P.A.
Health Information Form

Date: _____________
Patient Name: ___________________________D/O/B __________Age ______
Sex: ☐ Male ☐ Female Social Security #______________________
Address: ___________________________City_______State _____Zip ________
County _____________
Phone #(home) _________________(work) ____________________
(cell #)________________ Email:______________________________
Preferred Method of Contact:____
Employer ______________________ Employer Address___________________

Emergency Contact Name ____
Relationship To Patient _________________
Emergency Contact # _________________
List People We May Release Information To:
____
____

Guardian's Info If A Minor (under 18) ☐ Married ☐ Divorced ☐ Single
1St contact: ☐ Mother ☐ Father
Father's name_____________
Phone#(cell) _____________ (work) _____________
Mother's name_____________
Phone#(cell) _____________ (work)_____________

Insurance Info:

☐ Cigna ☐ Aetna ☐ Blue Cross Blue Shield
☐ United Healthcare ☐ Humana ☐ Tri Care
☐ PHCS ☐ First Health ☐ Coventry
☐ Medicare ☐ Medicaid ☐ Freedom Network
☐ Work Comp ☐ Other:_____________

Policy Holders Name:____
DOB:___________________ SSN___________________
Secondary Insurance Name: ____
Policy Holders Name, DOB, and SSN____________________________________
Work Related Injury? ☐ Yes ☐ No
If Yes, Date of injury____
Claim Number____
Work Comp Carrier Name And Address____________________________

Initial____

History Of Present Illness:

What is the reason for your visit today?

____

____

____

____

Symptoms:

☐ Pain ☐ Swelling ☐ Fracture
☐ Mass-painful ☐ Mass-discoloration ☐ Mass-increasing size
☐ Numbness/Tingling ☐ Deformity ☐ Weakness
☐ None ☐ Other _________________

Previous injury or trauma? ☐ Yes ☐ No

Work related injury? ☐ Yes ☐ No

How long have you had these symptoms? _____________Date of Onset______
Radiology studies taken? ☐ Yes ☐ No
Did you bring: CD or Films
☐ MRI ☐ CT ☐ Bone Scan ☐ X-ray ☐ Ultrasound

Doctor Only

Initial____

Past Medical History

☐ Arthritis	☐ Epilepsy/seizures	☐ Blood clots
☐ Asthma	☐ Diabetes	☐ High blood pressure
☐ Heart surgery	☐ Thyroid	☐ High cholesterol
☐ COPD	☐ Chronic bronchitis	☐ Cancer:______________

Men: Last prostate exam: _______________ Rectal exam:_________________
Women: Last mammogram ______________ Pap smear:________________

Past Surgical History

List any surgeries:

Surgery	Date

Current Medications

Preferred Pharmacy: ____
Address: __________________________________ Phone: _________________

Medications: please list all medications you are taking with dose and frequency: Please include any herbal or over the counter

☐ See med list

Drug	Dose/frequency

Drug allergies and reaction: ☐ No Know Drug Allergies

Drug	Reaction

Other Allergies:____

Social History

Occupation:________________________ Height________ Weight_________

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Right handed ☐ Left handed

Do you drink Alcohol? ☐Yes ☐ No
If yes, ☐ daily ☐ weekly ☐ monthly ☐ yearly Type:________________

Do you use tobacco products? ☐ Yes ☐ No
If yes, what type and how much________________________________

Do you use recreation drugs? ☐ Yes ☐ No
If yes, what type and how much________________________________

Do you consume caffeine? ☐ Yes ☐ No
If yes, how many ounces daily/weekly__________________________

Family History

☐Asthma	☐ Aneurysm	☐ Brain Tumor
☐ Cancer Type:_______	☐ Diabetes	☐ Epilepsy/seizures
☐ Headaches	☐ Heart Problems	☐ High blood pressure
☐ Kidney disease	☐ Lung disease	☐ Migraine
☐ Multiple sclerosis	☐ Stroke	☐ Psychiatric disease
☐ Thyroid	☐ None	

I authorize release of any information needed to act on the request of myself or the patient I am representing in order to best treat the patient. I request the payment of authorized benefits be made in my behalf, and I assign payment directly to MID-AMERICA SARCOMA INSTITUTE, P.A. I understand that I am responsible for any portion of the charges not paid by the insurance company.

Signature:
____

Patient Health History

General Health
☐ Good general health
☐ Recent weight change
☐ Loss of appetite
☐ Fatigue
☐ Fever/chills

Allergy
☐ Drug allergies: see above
☐ Food allergies:__________
☐ Hay fever
☐ Latex
☐ None

ENT
☐ Difficulty swallowing
☐ Loss of hearing/deaf
☐ Loss of smell/taste
☐ Ringing in ears
☐ Sinus infection
☐ Sores in mouth
☐ None

Eyes
☐ Blurred vision
☐ Double vision
☐ Glaucoma
☐ Injury
☐ Pain
☐ Contacts
☐ Glasses
☐ None

Gastrointestinal
☐ Blood in stools
☐ Increasing constipation
☐ Nausea/vomiting
☐ Persistent diarrhea
☐ Stomach/abdominal pain
☐ Ulcer
☐ Other:_____________
☐ None

Genitourinary
☐ Blood in urine
☐ Kidney stones
☐ Male: prostate disease
☐ Painful or burning urination
☐ Urgency with urination
☐ Urine retention/incontinence
☐ None

Heart
☐ Pain in chest
☐ High blood pressure
☐ High cholesterol

Muscles/Joints/bones
☐ Back pain
☐ Difficulty walking
☐ Joint pain
☐ Joint stiffness/swelling
☐ Muscle pain or tenderness
☐ Neck pain
☐ None

Neurological
☐ Balance trouble/weakness
☐ Neuropathy
☐ Tremors
☐ Numbness/tingling
☐ Black outs/loss of consciousness
☐ Difficulty speaking/walking
☐ Migraines
☐ Stroke
☐ Neuropathy
☐ Dizziness/light-headed
☐ Headaches
☐ Other:______________
☐ None

Psychiatric
☐ Depression
☐ Anxiety
☐ Eating disorder
☐ Other:_________
☐ None

Pulmonary
☐ Asthma
☐ Cough w/ blood
☐ Cancer:__________
☐ Chronic/frequent cough
☐ Emphysema
☐ Pneumonia
☐ Shortness of breath
☐ COPD
☐ Other:_____________
☐ None

Skin
☐ Rash or itching
☐ Sun sensitivity
☐ Hair loss
☐ Color changes
☐ Other:____________
☐ None

Sleep
☐ Snoring
☐ Nightmares
☐ Sleep well
☐ Feel rested when awake
☐ Fall asleep during day
☐ Sleep walking
☐ None

Initial____

PLEASE FILL IN **DOCTOR NAME** AND **FAX NUMBER** SO THAT OFFICE NOTES CAN BE FAXED TO YOUR REFERRING PHYSICANS:

REFERRING DR: ______________________________
____
____
PHONE: ______________________________
FAX#: ______________________________

FAMILY DR: ______________________________
____
____
PHONE: ______________________________
FAX#: ______________________________

OTHER DR'S: 1) ______________________________
____
____
PHONE: ______________________________
FAX#: ______________________________

2) ______________________________
____
____
PHONE: ______________________________
FAX#: ______________________________

Initial____