## Union Physician Services

## Patient Intake Form

**Last Name**: _____**First Name:**_____ **MI:**_____ **Date of Birth:** _____

**Age:** _____ **Male or Female:** _____ **Social Security #:**_____

**Home Address:** _____
*Street* *City* *State* *Zip*

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Email Address:** _____

**Employer:** _____ **Primary Language Spoken:** _____

**Ethnicity:** ☐ Non-Hispanic ☐ Hispanic ☐ Other

**Race**: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

**Referring Doctor:** _____

**Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced

**Spouse Name:** _____ **Date of Birth:** _____

### Primary Insurance

**Insurance Co:** _____ **Policy #** _____**Group #**_____

**Subscribers Name:** _____**SS#**_____**DOB**_____

**Address if Different than Patient:** **Phone:** **Relationship to Patient:**

_____ _____ _____

*Street* *City* *State* *Zip*

### Secondary Insurance

**Insurance Co:** _____ **Policy #** _____**Group #**_____

**Subscribers Name:** _____**SS#**_____**DOB**_____

**Address if Different than Patient:** **Phone:** **Relationship to Patient:**

_____ _____ _____

*Street* *City* *State* *Zip*

**Emergency Contact (EC) / Release of Information (ROI)- Please Check the Boxes that Apply:**

**Name of Person to Contact in case of Emergency/ or we may release information to:**

**Name:** _____ **Phone:** _____**Relationship:** _____ ☐EC ☐ROI

**Name:** _____ **Phone:** _____**Relationship:** _____ ☐EC ☐ROI

**Name:** _____ **Phone:** _____**Relationship:** _____ ☐EC ☐ROI

**Communication:** ☐ Message may be left ☐ Answering Machine ☐ Family Member_____

**Living Will?** ☐N ☐Y **Durable Power of Attorney?** ☐N ☐Y (if yes) Name:_____

Phone: _____

Relationship: _____

*Print:*_____ *Signature:*_____ *Date:* _____



Form No. 8999-005Q (4/18) Union Hospital, Dover, Ohio 44622

UNION PHYSICIAN SERVICES
A DIVISION OF UNION HOSPITAL

**Patient Initials:_____ DOB: _____ Height:_____ Weight: _____ lbs**

## Current Symptoms/ Reason for Visit : Length of time:

| | |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |

**Are your Symptoms?**

| | Yes | No | When |
|---|---|---|---|
| Work Related? | ___ | ___ | _____ |
| Injury Related? | ___ | ___ | _____ |
| Did you stop working? | ___ | ___ | _____ |
| Did you return? | ___ | ___ | _____ |

## Recent Testing? (Last 6 Months) □No □Yes

| Test Name | Date |
|---|---|
| 1. | |
| 2. | |
| 3. | |

**Current Symptoms: Please Check All that Apply**

□ Abdominal Pain
□ Back Pain
□ Blood in Urine
□ Bloody/ tarry stool
□ Bruise Easily
□ Change in bowel habits
□ Chest Pain
□ Cold numb feet
□ Constipation
□ Convulsions/ Seizures
□ Cough
□ Diarrhea
□ Difficulty Swallowing
□ Dizziness/ Fainting
□ Ear Infection
□ Failing Vision
□ Fatigue
□ Fever
□Foot Pain
□ Frequent Urination
□ Hair Loss
□ Headaches
□ Hemorrhoids
□ Hernia
□ Hives
□ Hoarseness
□ Indigestion/ Heartburn
□ Insomnia
□ Joint Pain
□ Leg Pain
□ Loss of Appetite
□ Lumps/ Masses
□ Memory Loss
□ Moodiness
□ Muscle Weakness
□ Nausea/ Vomiting
□ Nervousness
□ Night Sweats
□ Nosebleeds
□ Numbness/ Tingling
□ Pain/ Bleeding during Sex
□ Painful Urination
□ Phobias
□ Rashes
□ Ringing in Ears
□ Sexual Dysfunction
□ Shortness of Breath
□ Sinus Trouble
□ Sore Throat
□ Swollen Ankles
□ Tooth/ Gum Trouble
□ Tremors
□ Urethral Discharge
□ Varicose Veins
□ Weight Loss


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**Patient Initials: _____ DOB: _____**

| Previous Surgery | Hospital | Date |
|---|---|---|
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**Problems with Anesthesia in the past? □N □Y-Explain_____**
**Do you have a Pacemaker? □N □Y**
**Please list any serious injuries: _____**

| Family History | Illness | Deceased | Living |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother | | | |
| Sister | | | |
| Children | | | |
| Other | | | |

## Social History

Do you live alone? □Y □ N- who? _____
Number of Children- _____
Do you exercise regularly? □ Y □ N
Which is your Dominant Hand? □ Right □Left
Highest grade level completed? _____
Occupation? _____
Are you on a special diet? _____

**Do you use any of the following- Please check all that apply**

| | Yes | Never | Quit | Amount per Day |
|---|---|---|---|---|
| Recreational Drugs | | | | |
| Alcohol | | | | |
| Tobacco | | | | |
| Caffeine | | | | |

**Please complete if applicable:**
Are you planning a pregnancy? □ Y □ N
What kind of contraception are you using currently? _____
Are you pregnant now? □ Y □ N
When was your last menstrual cycle? _____


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**Patient Initials:_____ DOB:_____**

| **Patient Medical History** | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS | | | Eczema | | | Multiple Sclerosis | | |
| Anemia | | | Emphysema | | | Mumps | | |
| Anxiety | | | Epilepsy | | | Muscle Disorder | | |
| Arrhythmia | | | Eye/ Ear Disorder | | | Neuropathy | | |
| Arthritis | | | Genetic Defects | | | Osteoporosis | | |
| Asthma | | | Gout | | | Parkinson's Disease | | |
| Birth Defect: _____ | | | Hayfever/ Allergies | | | Phlebitis | | |
| Blood Disorder/ Clot | | | Heart Attack | | | Pneumonia | | |
| Bone/ Joint Disorder | | | Heart Disease | | | Polio | | |
| Bronchitis | | | Heart Murmur | | | Prostate Disease | | |
| Cancer: Type _____ | | | Hepatitis: Type _____ | | | Psoriasis | | |
| Chicken Pox | | | Herpes | | | Rubella | | |
| Cirrhosis/ Liver | | | High Blood Pressure | | | Seizures | | |
| Colitis | | | Jaundice | | | Skin Disease | | |
| Congestive Heart Failure | | | Kidney Failure | | | Sleep Apnea | | |
| COPD | | | Kidney Stones | | | Stroke | | |
| Crohn's Disease | | | Lactose Intolerant | | | Tetanus | | |
| Deep Vein Thrombosis | | | Low Blood Pressure | | | Thyroid Disease | | |
| Depression | | | Lung Disease | | | Tuberculosis | | |
| Diabetes | | | Measles | | | Ulcers | | |
| Diptheria | | | Mental Illness | | | Venereal Disease | | |
| Diverticulosis | | | Migraines | | | Other: _____ | | |

## Local Pharmacy: _____ Mail In: _____

| **Current Medications** | **Dose** | **Frequency** |
|---|---|---|
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**Allergies to Medication? □No □Yes**

**List: _____**

**Latex Allergy? □N □Y**

**Metal Allergy? □N □Y**



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