PATIENT INFORMATION HISTORY FORM **Today's date** ____________________

Name:____________________ **Birth date:**__________ **Social Security #**____________________

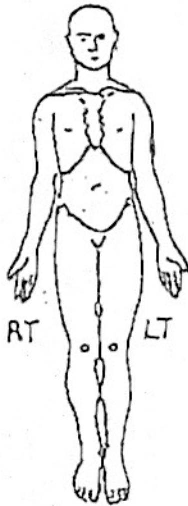
Circle one: Personal injury/accident Vehicular accident Work injury Illness

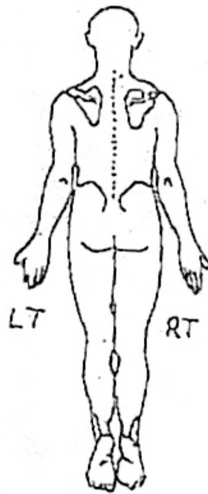
Date of injury/accident __________ Date of onset of symptoms(non-accident) ____________________
If injury/accident explain how it occurred ____________________

____

List current area of pain or symptom ____________________
Mark on diagram, current problem

PLEASE ARRIVE 20 MINUTES EARLY FOR REGISTRATION AND POSSIBLE XRAYS





Do you smoke/chew tobacco?________ How much ____________________ If you formerly smoked, how long since you quit?____________________
Do you have history of substance abuse ? __________ What type of substance ____________________
Approximately how often and how much alcohol do you consume____________________
Approximately how often and how much caffeine do you consume____________________

Have you been diagnosed with any of the following currently or in the past:

Seizures / stroke	yes / no	Kidney / urinary problems	yes / no
Infectious disease (TB/ HIV)	yes / no	Liver / Hepatitis A , B, or C	yes / no
Hormone / thyroid problems	yes / no	Lung / breathing problems	yes / no
Diabetes	yes / no	Stomach problems	yes / no
Cancer or leukemia	yes / no	Ear / Nose / Throat	yes / no
High blood pressure	yes / no	Heart / circulation problems	yes / no
Bleeding problems	yes / no	History blood transfusion	yes / no
If yes to any question , please explain below		Other problems	yes / no

____

____

____

____

List any medical problems your parents or siblings have____________________

____

PLEASE LIST ANY SURGERY YOU HAVE HAD

DATE	DOCTOR	SURGERY

Date of last tetanus: ____________________

Please list your current medications

MEDICATION	DOSE	HOW OFTEN	TAKING FOR	DOCTOR

Allergies: Food Yes / No List:____________________
Medicine Yes / No List:____________________
Latex Yes / No

Pharmacy Name / Location____________________

Family Doctor____________________ phone ____________________

General Information

Are you entitled to Medicare based on age? (65 or older) Yes / No

Are you entitled to Medicare based on disability? Yes / No

Are you entitled to Medicare based on End Stage Renal Yes / No

Has the Veterans Affairs authorized treatment and agreed to pay for care at the University of Iowa or Wisconsin Yes / No

Are you receiving Black Lung benefits? Yes / No

Are these services to be paid for by another government program? Yes / No

Patient signature ____________________ Date ____________________

(your signature denotes the accuracy of your information) **RN initials** ____________________