

PATIENT MEDICAL HISTORY page 1

Name: _____

Date: _____

Describe in detail your medical problem today: _____

Where were you when your accident/injury/illness occurred? _____

Were you knocked unconscious? Yes No **Auto accidents only:** Were seat belts in use? Y N

What activity causes or worsens your pain? _____

What have you done to obtain relief from the pain? _____

Do you experience any other symptoms with you pain? If so, what? _____

On a scale of 1 (No pain) to 10 (Worst pain imaginable), circle the number that best describes your pain:

1 2 3 4 5 6 7 8 9 10

Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation by using arrows and include all affected areas.

NUMBNESS

PINS & NEEDLES

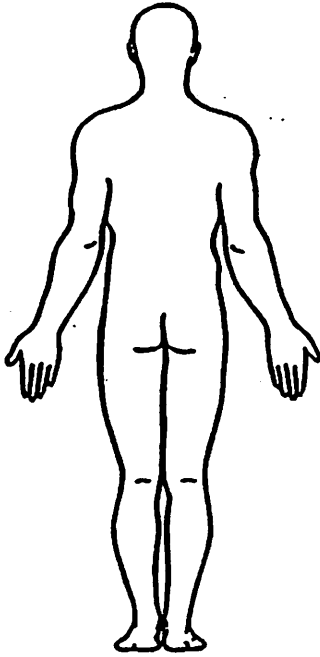
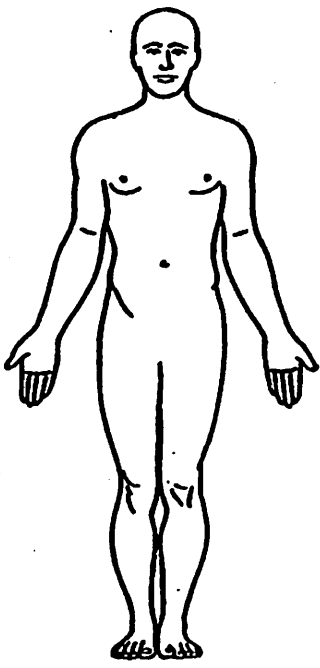
OOOOO
OOOOO
OOOOO

BURNING

XXXXX
XXXXX
XXXXX

STABBING

/////
/////



PATIENT MEDICAL HISTORY page 2

Where is your pain? _____

How long have you been experiencing this pain? _____

When do you most often experience your pain? ___ morning ___ afternoon ___ evening ___ night

Have you had a previous on-the-job-injury? ___ Yes ___ No If "Yes," when? _____

Have you ever received compensation for work-related injuries in the past? ___ Yes ___ No If "Yes," when? _____

Are you involved in legal action for this problem? ___ Yes ___ No Do you have an attorney for this problem? ___ Yes ___ No

If so, please list name, address and phone number: _____

List in order of occurrence any doctors, hospitals or therapists you've seen for your current problem and the day you were released.

Dr./ Therapist	Date	Tests Performed/ Treatment	Hospital	Surgery Performed	Released	Date

Have you had diagnostic studies done for this problem? When and where were they done?

TEST	Circle one	Date	Facility
X-Rays	Yes No		
CT Scans	Yes No		
MRI	Yes No		
Bone Scan	Yes No		

PAST MEDICAL HISTORY

List any medical conditions/surgeries not related to this accident/injury. Also list areas that were injured and dates.

Condition/Surgery	Doctor Used	Date (Approx)	Injured area of body	Work Related	Impairment	Auto Accident?
					%	
					%	
					%	
					%	

WOMEN ONLY: Are you pregnant at this time? ___ Yes ___ No Have you ever been pregnant? ___ Yes ___ No

PATIENT MEDICAL HISTORY page 3

List any medications you are taking (Prescription, over the counter or contraceptive medications.) List doses as well.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

List ALL allergies (DRUGS AND OTHERS): _____

REVIEW OF SYSTEMS:

Do you currently (or have you ever) had any of the following: Circle if "Yes" and explain in space.

General Health:	Exposure to communicable disease, weight loss, fever, etc.	
Eyes:	Glaucoma, cataracts, vision problem, etc.	
Ears/Nose/Mouth/Throat:	Hearing, swallowing problems, etc.	
Cardiovascular:	Heart disease, hypertension, angina, heart attack, pacemaker, etc.	
Respiratory:	Asthma, bronchitis, COPD, tuberculosis, pneumonia, etc.	
Gastrointestinal:	Stomach or colon problems, diarrhea, constipation, ulcers, etc.	
Genitourinary:	Bladder or kidney problems	
Musculoskeletal:	Arthritis, difficulty ambulating, use of cane, walker, w/c, etc.	
Integumentary:	Bruising, swelling, scars, marks, tattoos, skin problems, etc.	
Psychiatric:	Mental or emotional problems, depression, mental illness, etc.	
Neurological:	Stroke, epilepsy, seizures, loss of sensation or function, etc.	
Hematologic/Lymphatic:	Unusual bleeding, lumps or masses, liver problems, etc.	
Endocrine:	Diabetes, thyroid or hormone problems, etc.	
Allergic/Immunologic:	Allergies, problems with anesthesia, current immunizations.	

SOCIAL HISTORY:

Are You married?	Yes	No	If yes, for how long?
If not married, do you live alone?	Yes	No	If not, what is your relationship?
Did you graduate from high school?	Yes	No	What level of education did you obtain?
Are you employed?	Yes	No	What is your occupation?
Are you retired?	Yes	No	What was your occupation?

Do you use alcohol? Yes No What do you drink? _____ How often? _____
 Do you use tobacco products? Yes No If yes, what? _____ Packs per day? _____

FAMILY HISTORY

Has any member of your family had or do they currently have (check the ones that apply):

Hepatitis Cancer Tuberculosis Diabetes Kidney Problems Other
 Heart Problems Asthma Lung Problems Epilepsy High Blood Pressure

If a member of your immediate family is deceased, please state the cause of death: _____

Norman Neurosurgical, P.C.
J. Michael Alvis, MD FACS
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Norman, OK 73069
(405) 321-6347

Medical Office 405-321-6347

Billing Office 405-329-7300

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT
OR HEALTHCARE OPERATIONS**

I understand that as part of my health and medical care, J. MICHAEL ALVIS, M.D. and NORMAN NEUROSURGICAL, P.C., originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment:
- A means of communication among the health professionals who contribute to my care:
- A source of information for applying my diagnosis and treatment information to my bill:
- A means for a third-party payer to verify that services were billed as actually provided:
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Norman Neurosurgical, P.C. reserves the right to change their notice and practices, but that prior to implementation, will make available to me a copy of any revised notice. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Alvis is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law, we are required to notify you that: The information authorized for release may include records which may indicate the presence of a communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

In addition to the releases outlined above, information may be released to the following individuals or organizations for the indicated purpose:

_____	_____
_____	_____
_____	_____

DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Mike Alvis has an ownership interest in Community Hospital and Northwest Surgical Hospital.
2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.
3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

Signature of Patient

Signature of Parent or Guardian
(if applicable)

Print Name of Patient

Print Name of Parent or Guardian

Dated: _____

