Midwest Regional Health Services

YOUR HOME FOR BETTER HEALTH

Today's Date: _____

Patient Name: _____ Patient DOB: _____

Address: _____ City, State, Zip: _____

Social Security #: _____ Marital Status: Married/Single/Divorced/Widowed (Circle One)

Primary Phone: _____ Circle One: Home Work Cell

Secondary Phone: _____ Circle One: Home Work Cell

Email Address: _____

Billing Address: ☐ Check if address is same as patient

Name: _____

Address: _____ City, State, Zip: _____

Preferred ***Contact Method***: E-mail/Telephone (Circle One)

Preferred ***Language***: English/Spanish Other_____

Race: Caucasian/African American/Hispanic/Asian/Native American Other_____

Primary Insurance Company: _____

Policy Holder's name_____ Date of Birth _____ SSN _____

Secondary Insurance Company: _____

Policy Holder's name_____ Date of Birth _____SSN _____

Emergency Contact: _____ Phone #: _____ Relationship: _____
(Circle One) Home Work Cell

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(Circle One) Home Work Cell

Assignment and Release: I understand that I am financially responsible for charges incurred for services rendered. Full payment is expected at the time services are rendered. As a courtesy to you, we will submit your medical claim to your insurance company. I hereby authorize, and assign direct payment of my medical insurance benefits to Midwest Regional Health Services, LLC. I also authorize my medical provider to release my information requested by my medical insurance company.

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Patient's Name Date

Midwest Regional Health Services

YOUR HOME FOR BETTER HEALTH

The Wellness Place
Healthcare for All Ages

2727 S.144 St., Ste 280, Omaha & 818 Village Square, Gretna
Office: 4027785490 Fax: 4026141404

FOR OFFICE USE ONLY:

Ht: _____ Wt: _____ Temp: _____ BP: _____ P: _____ R:_____

Welcome to our clinic! To ensure that we create a complete electronic chart for you please fill out the following information. Below is the address, phone number & email we have on file for you. Please review this information and make sure it is correct.

Email: _____

Mother's Name & Phone (if minor):_____

Father's Name & Phone (if minor):_____

Legal Guardian Name & Phone (if minor): _____
Relationship to patient:_____

Briefly describe why you are coming into clinic today: _____

Past Medical History: Please list any past or current medical illnesses.

Past Surgical History: Please list all past surgeries.

Should your Physician order laboratory studies, please circle your prefered lab:

NMC/Regional Lab **P-Lab** **Other**_____

If your Physician prescribes, or refills, medications today please write down the pharmacy you prefer. Please indicate if you prefer a 30 or 90 day refill on long term medications.

_____ **30 day** **90 day**

Please list any **Allergies (Meds, Foods, Environmental)** you have had in the past.

_____

_____

Please list any **Medications** that you are taking. Please include doses and the frequency with which you are taking the medications as well as any vitamins or herbal supplements.

_____

_____

_____

_____

_____

_____

Females Only:

Birth Control Method: _____ Birth Control Pill Name: _____

Number of Pregnancies:_____ Miscarriages: _____ Abortions: _____

1st day of last period: _____ How old were you when your started your period?_____

Menstrual Flow: Regular, Irregular, Painful/Cramps, other_____

Days of Flow: _____ # of Days in Cycle: _____

Menopause at age: _____ Hormone replacement (Current or Past) _____

Family History: Please write in any family medical problems (heart disease, diabetes, high blood pressure, thyroid problems, cancer, etc.). If passed away, please include the age as well.

Father _____ Mother _____

Brothers _____ Sisters _____

Sons _____ Daughters _____

Grandfather (Dad's side) _____ Grandfather (Mom's side) _____

Grandmother (Dad's side) _____ Grandmother (Mom's side) _____

Social History:

Tobacco Use: past - current - never (please circle one)
(packs a day): _____ How Long? _____ Interested in stopping? _____

Alcohol Use: _____ Drug Use: _____

Caffeine: _____ Exercise Routine: _____

Marital Status: _____ Children: _____ Occupation: _____

Please update your preventative care history if applicable to your gender and age.

If over 50 or have colon disease, when was your last **Colonoscopy** & results?
Cologuard & results?

Hemoccult & results?

If menopausal (female) or history of chronic steroid use, when was your last **Dexa Scan(Bone density test)** & result?
What was the date of your last **Pap Smear** & result?
If over 35, what was the date of your last **Mammogram** & result?
When was your last **Tetanus/Pertussis shot**?
When was your last **Flu shot?**
If 65, or have diabetes, lung or heart disease, or are a smoker, when was your last **Pneumonia shot**?
If age greater than 59, have you received the **Shingles(Zostavax) shot** & if yes when?

Do you have an Advanced Directive or Living Will?

If you are a Diabetic, *how many times a day do you test your blood sugars?*

Review of Systems. Have you experienced any of the following recently? (Circle all that apply)

GENERAL: chills, decreased appetite, difficulty sleeping, fatigue, fever, night sweats, weight gain, weight loss

EYES: discharge, double vision, dryness, excessive tearing, eye pain, irritation, itching, light sensitivity, vision changes, wears corrective lenses

EARS/NOSE/MOUTH/THROAT: bleeding gums, bloody nose, congestion, difficulty breathing through nose, difficulty swallowing, ear fullness, earache, hearing loss, hoarseness, nasal draining, ringing in the ears, sinus pain, sore throat, vertigo

CARDIO/VASCULAR: chest pain, difficulty breathing at night, difficulty breathing when laying flat, heart pounding, leg pain with walking, leg swelling, lightheadedness, palpitations, shortness of breath with exertion, varicosities

RESPIRATORY: cough, coughing up blood, excessive sputum, recent upper respiratory infections, shortness of breath, snoring, stops breathing at night, tightness in the chest, wheezing

GASTROINTESTINAL: abdominal pain, black/tarry stools, bloating, blood in stool, change in caliber of stools, constipation, diarrhea, food intolerance, hemorrhoids, loss of appetite, nausea, reflux/indigestion, vomiting

GENITOURINARY - FEMALE: bladder control issues, blood in urine, decreased libido, heavy periods, inability to empty bladder, irregular periods, missed periods, pain with intercourse, painful periods, painful urination, pelvic pain, trouble starting urinary stream, urinary frequency, urinary urgency, urinating more than twice per night, vaginal discharge, vaginal dryness

GENITOURINARY - MALE: blood in urine, decreased libido, difficulty with erections, incontinence, painful urination, penile discharge, poor stream, straining to urinate, urinary frequency, urinating more than twice per night

MUSCULOSKELETAL: arthritis, back pain, decreased range of motion, decreased strength, joint pain, joint swelling, muscle aches, muscle cramps, weakness

NEUROLOGICAL: difficulty concentrating, disturbances in coordination, dizziness, falls, headache, loss of consciousness, memory loss, numbness, poor balance, tingling, tremor, weakness, visual disturbances

SKIN/DERM: breast lumps/masses, breast pain, brittle nails, change in skin lesions, dry skin, hair loss, itching, non-healing lesions, rash, suspicious lesions

PSYCHIATRIC: anxiety, depression, irritability, mood changes, stress, suicidal thoughts, thoughts of violence, trouble coping, weeping

ENDOCRINE: cold intolerance, excessive hunger, excessive thirst, excessive urination, hair changes, heat intolerance, nail changes, poor energy, skin changes, weight gain, weight loss

HEMATOLOGIC/LYMPHATIC: bleeding, easy bruising, swollen lymph glands

ALLERGIC/IMMUNOLOGIC: food sensitivities, hay fever, hives, recurrent infections, seasonal allergies

ACTIVITIES OF DAILY LIVING: difficulty managing finances, difficulty with bathing, difficulty with dressing, difficulty with eating, difficulty with toileting, difficulty with grooming, difficulty with transferring, difficulty with driving, difficulty with public transportation, difficulty with frequent falls, difficulty with mobility problems

Vaccines to think about: (tell doctor if you think you're due)

1. Flu Shot-recommended yearly for all ages during months of October through March.
2. Pneumonia Shot-age 65 or older, or individual with chronic medical illnesses, or smoker.
3. Tetanus-every 10 years, there is a new version available with whooping cough added back in.
4. Gardasil Vaccine-For Females to prevent HPV, which causes cervical cancer (Ages 9-27 years).
5. Hepatitis A - 2 shots 6 months apart for anyone doing foreign travel, having Hepatitis C, working in health care or just desiring protection against the disease.
6. Zostavax - Shingles vaccine available for those age 60 and above. Some may need to get at pharmacies.

Thank you very much.