PATIENT INFORMATION FORM

PLEASE ANSWER ALL QUESTIONS

TMC
TRUMAN MEDICAL CENTER
Lakewood

NAME _____ AGE_____ BIRTHDATE_____
last first middle initial

PATIENT'S SOCIAL SECURITY #_____ PATIENT'S DRIVER'S LICENSE#_____

HOME ADDRESS_____
street apt number

_____
city state zip code

HOME (_____) _____CELL (_____) _____ WORK (_____)_____

BEST CONTACT NUMBER (Please circle one) HOME / CELL / WORK

E-MAIL_____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____
street city state zip code

NAME OF SPOUSE/PARENT/RESPONSIBLE PARTY (if other than patient)_____

HOME ADDRESS_____
street city state zip code

HOME (_____) _____CELL (_____) _____ WORK (_____)_____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____
street city state zip code

EMERGENCY CONTACT_____

RELATIONSHIP_____ PHONE_____

REFERRED BY (Please circle one) MD / FRIEND / FAMILY / OTHER

PRIMARY PHYSICIAN_____

ADDRESS_____

REASON FOR CONSULTATION (LIST ALL)_____

_____

SELF PAY

I do not have health insurance and will be responsible for services rendered here at Medical Imaging Eastland/Breast Center. I agree to pay the full and entire amount for services rendered.

_____

PATIENT/GUARANTOR SIGNATURE DATE

MEDICAL HISTORY

TMC
TRUMAN MEDICAL CENTER
Lakewood

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

SURGERY (OPERATIONS AND COSMETIC SURGERY) _____

	TYPE	DATE	COMPICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			
5.			
6.			

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY PHYSICIAN

EXPLAIN _____

_____

_____

ADMISSIONS TO HOSPITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

	TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1.			
2.			
3.			
4.			

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

OTHERS _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (with cuts, tooth extractions, pregnancy, surgery)

EXPLAIN _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? YES NO

EXPLAIN _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA? YES NO

EXPLAIN _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO

ARE YOU PREGNANT? YES NO

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (CIRCLE YES OR NO)

YES_____ NO_____ INTRAVENEOUS DRUGS
YES_____ NO_____ INFECTIOUS DISEASES
YES_____ NO_____ TB
YES_____ NO_____ HEPATITIS
YES_____ NO_____ HIV/AIDS
YES_____ NO_____ LIVER TRANSPLANT

IF YES TO ANY, EXPLAIN _____

CONTINUED ON BACK

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN_____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRCLE YES, NO OR UNCERTAIN)

HAD ALL KNOW BABY SHOTS?	YES	NO	UNCERTAIN
HAD POLIO IMMUNIZATION?	YES	NO	UNCERTAIN
HAD RHEUMATIC FEVER?	YES	NO	UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER_____ SISTER_____

_____ _____

FATHER_____ BROTHER_____

_____ _____

OTHER RELATIVE_____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

HEAD	NO	IF YES EXPLAIN_____
EYES	NO	IF YES EXPLAIN_____
EARS	NO	IF YES EXPLAIN_____
THYROID	NO	IF YES EXPLAIN_____
LUNGS	NO	IF YES EXPLAIN_____
HEART	NO	IF YES EXPLAIN_____
BLOOD PRESSURE OR VESSELS	NO	IF YES EXPLAIN_____
DIGESTIVE SYSTEM	NO	IF YES EXPLAIN_____
LIVER	NO	IF YES EXPLAIN_____
MUSCLES-BONES	NO	IF YES EXPLAIN_____
REPRODUCTIVE ORGANS	NO	IF YES EXPLAIN_____
KIDNEYS-BLADDER	NO	IF YES EXPLAIN_____
UNSIGHTLY SCARS	NO	IF YES EXPLAIN_____
OTHER	NO	IF YES EXPLAIN_____
DISEASE AFFECTING IMMUNE SYSTEM	NO	IF YES EXPLAIN_____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S) PLEASE LIST

_____

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME_____

PHYSICIAN_____

ADDRESS_____

BY REPRESENTATION OF SIGNATURE BELOW, I HEARBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

MEDICAL IMAGING EASTLAND
19000 EAST EASTLAND CENTER CT.
INDEPENDENCE, MO 64055

_____ _____

PATIENT SIGNATURE DATE