MEDICAL DATA SHEET

For Patients 18 years of age and older

NAME: _____ DATE: ___/___/___

AGE: _____ DOB: ___/___/___

1. What is the main reason you are seeking a physician's advice?

_____

_____

2. Please list all allergies:

Drug Allergies: _____ Other Allergies: _____

3. List health information for family members

Relationship	Age Attained	Deceased?	State of Health Known Disease of Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Spouse			

4. List family members who are seeing physicians of Wilmington Health:

5. Do you have any blood relatives who have any of the following:
(Please circle and indicate relationship)

TB
Emphysema
Asthma
Heart Disease
High Blood Pressure
Stroke
Diabetes
Sickle Cell Anemia

Kidney Disease
Blood Disorder
Bleeding Tendency
Epilepsy
Nervous Disorder
Suicide

Breast Cancer
Colon Cancer
Prostate Cancer
Ovarian Cancer
Uterine Cancer

NAME: _____
DATE: _____

6. Past Medical History

   Previous hospitalizations (In chronological order)

   a. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____
   b. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____
   c. Date: _____ Hospital: _____
      Reason for admission:_____
      Surgical procedures? _____

7. Have you had any of the following conditions? (please circle those that apply)

Heart Disease	Ulcers	Blood Clots	Other Medical Problems (List)
High Blood Pressure	Gallstones	Seizures	
Stroke	Pancreatitis	Nervous Illness	
Asthma	Kidney Disease	Alcoholism	
Emphysema	Diabetes	Cancer	
Tuberculosis	Bleeding Tendency	Blood Disorders	

8. Habits:

   Amount of alcohol consumed per week: _____
   Number of cigarettes smoked per day: _____
   Number of years Smoking: _____

9. Please list travels off the North American Continent or Europe:
   Date: _____ Place: _____

10. Please list all medications you are presently taking: (Doses and directions). Please include over the counter medications (such as pain relievers, vitamins, supplements and herbals).

    _____
    _____

11. Have the following tests been performed elsewhere? Indicate date)

Colonoscopy	_____
PSA	_____
Pap Smear	_____
Mammogram	_____
Bone Density	_____
Tuberculin Test	_____
Chest X-Ray	_____
EKG	_____

12. Name of pharmacy you use to fill your prescriptions:_____

Name_____

Date_____

REVIEW OF SYSTEMS

Do you suffer from or have difficulty with any of the below listed symptoms?
Check yes or no and circle specific problem if more than one are listed together.

Yes No

HEAD

- ☐ ☐ Trouble with eyesight
- ☐ ☐ Trouble with ears or hearing
- ☐ ☐ Nasal discharge
- ☐ ☐ Hay Fever, frequent sneezing
- ☐ ☐ Sinus trouble, post nasal drip
- ☐ ☐ Serious head injury

THROAT

- ☐ ☐ Hoarseness (persistent)
- ☐ ☐ Ulcer of tongue or mouth
- ☐ ☐ Trouble with gums or teeth
- ☐ ☐ Sore throat

GLANDULAR

- ☐ ☐ Enlargement of thyroid gland
- ☐ ☐ Nodes or kernels anywhere

LUNGS

- ☐ ☐ Asthma, wheezing
- ☐ ☐ Chronic cough
- ☐ ☐ Cough up blood
- ☐ ☐ Tuberculosis
- ☐ ☐ Shortness of breath
- ☐ ☐ Exposure to asbestos or other occupational hazard

CARDIOVASCULAR

- ☐ ☐ High Blood Pressure
- ☐ ☐ Chest pain on exercise
- ☐ ☐ Shortness of breath with mild exercise
- ☐ ☐ Irregular beat or palpitation of heart
- ☐ ☐ Pain or cramps in legs with exercise
- ☐ ☐ Swelling or edema of ankles
- ☐ ☐ History of Rheumatic Fever
  - Heart Attack
  - Enlarged Heart
  - Awaken at night with shortness of breath

Yes No

SKIN

- ☐ ☐ Rash
- ☐ ☐ Tumor on skin

BLADDER AND KIDNEY

- ☐ ☐ Frequency, urgency or pain with urination
- ☐ ☐ Passed blood or kidney stone
- ☐ ☐ Trouble starting or stopping of urinary stream
- ☐ ☐ Getting up at night to urinate more than twice
- ☐ ☐ Prostate disease
- ☐ ☐ Have you had a venereal disease

STOMACH AND BOWELS

- ☐ ☐ Trouble swallowing
- ☐ ☐ Abdominal pain, nausea, vomiting
- ☐ ☐ Foods disagree with you
- ☐ ☐ Stomach ulcer/Duodenal ulcer
- ☐ ☐ Vomit blood/Black bowel movement
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Hemorrhoids or rectal itching
- ☐ ☐ Blood or mucus in the stool
- ☐ ☐ Hernia or operated hernia
- ☐ ☐ Liver disease
- ☐ ☐ Hepatitis
- ☐ ☐ Jaundice

MUSCLES AND BONES

- ☐ ☐ Backache
- ☐ ☐ Pain or aching in feet or arches
- ☐ ☐ Numbness or tingling anywhere
- ☐ ☐ Pains or swelling of joints
- ☐ ☐ Arthritis

Yes No

ENDOCRINE

- ☐ ☐ Increased thirst, hunger
- ☐ ☐ Sudden weight change
- ☐ ☐ Sensitive to heat/cold
- ☐ ☐ Change in skin, body hair
- ☐ ☐ Change is sex drive

MISCELLANEOUS

- ☐ ☐ Disturbance of sleep
- ☐ ☐ Dizzy spells, headaches or fainting
- ☐ ☐ Are you depressed
- ☐ ☐ Excessive fatigue or nervousness
- ☐ ☐ Convulsions or been unconscious
- ☐ ☐ Tumor or cancer
- ☐ ☐ Anemia or difficulty with bleeding
- ☐ ☐ Sexual problems
- ☐ ☐ Have you considered suicide
- ☐ ☐ Excessive worry
- ☐ ☐ Other Important Health Information not noted above_____

_____

_____

_____

FEMALE

- ☐ ☐ Pain, irregular or excessive bleeding
- ☐ ☐ Date of last period _____
- ☐ ☐ Bleeding after menopause
- ☐ ☐ Discharge from vagina
- ☐ ☐ Children How many _____
- ☐ ☐ Breasts Lumps, soreness, discharge
- ☐ ☐ Any problems with pregnancies

REMARKS

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B below**.** I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Name: _____

Address: _____

Account Number: _____ Social Security Number: _____

Date of Birth: _____ Telephone:_____

Section B: Protected Health Information to Be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

☐ All medical information, except psychotherapy information.

☐ Psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

☐ Specific information (please describe): _____

_____

Entities Authorized to Use or Disclose: Wilmington Health

Families, Friends and Other Authorized to receive and Use: (please name specifically any family/friends to which we may release your protected health information either in writing or verbally):

_____ _____

_____ _____

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

☐ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care.

☐ At the request of the individual

☐ Other:_____

SECTION E: Expiration

This authorization will expire (complete one):

☐ Until I revoke permission in writing

☐ On the occurrence of the following event:_____

☐ 2 Years after my death

☐ Future Date ____/____/

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 772-1307 **Address:** 1202 Medical Center Drive, Wilmington, NC 28401
E-mail: privacy @wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

Voicemail and Text Message Notifications

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine please complete the section below.

Wilmington Health may leave a message regarding my medical information on the answering machine at this number (_____)_____-_____

**Wilmington Health may send appointment reminders via text message to the following number (_____)_____-_____

☐ Wilmington Health may not communicate appointment reminders via text message

** Text messaging is an offered service, however not required for appointment reminder notification. Note Text messaging charges may apply, based on your service contract with your service provider.

I acknowledge that I have been made aware of Wilmington Health's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Wilmington Health Notice of Privacy Practices.

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: _____Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.