THE UNIVERSITY OF KANSAS HOSPITAL

NEW PATIENT INFORMATION & REGISTRATION

Today's Date _____

Please check the box next to the name of the provider you are scheduled to see:

- ☐ David Anderson, M.D.
- ☐ Greg Erb, M.D.
- ☐ Tyler Fox, M.D.
- ☐ Randy Goldstein, D.O..
- ☐ Archie Heddings, M.D.
- ☐ Kelly Hendricks. M.D.
- ☐ Greg Horton, M.D.
- ☐ Vincent Key, M.D.
- ☐ Stephen Munns, M.D.
- ☐ Joshua Nelson, M.D.
- ☐ John Sojka, M.D.
- ☐ Kimberly Templeton, M.D.
- ☐ Michael Tilley, M.D.
- ☐ E. Bruce Toby, M.D.
- ☐ James Voos, M.D.
- ☐ Lindsay Hall, P.A.
- ☐ Stephanie Caldwell, P.A.
- ☐ Tony Casto, P.A.
- ☐ Troy Stucker, P.A.
- ☐ Erin Christensen, APRN

PATIENT INFORMATION

Last Name: _____ First Name _____ MI _____

Address _____ Day Phone ( ) _____

City _____ ST _____ ZIP _____ Evening Phone ( ) _____

County _____ Country _____ Cell Phone ( ) _____

Email Address _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ / _____ / _____ Age _____

Social Security Number _____ - _____ - _____ **Race:** ☐ African/Amer/Black ☐ Amer Indian/Alaska Native ☐ Caucasian/White ☐ Native Hawaiian/other Pacific Islander ☐ Multi-racial ☐ Other _____

Gender: ☐ Male ☐ Female

Religion: ☐ Christian ☐ Catholic ☐ Buddhist ☐ Muslim ☐ Jewish ☐ Non-Denominational ☐ None ☐ Unknown ☐ Other _____

Ethnicity: ☐ Hispanic, Latino or Spanish Origin ☐ Not Hispanic, Latino or Spanish Origin

Emergency Contact: _____ Relationship to Patient _____ Phone _____

Patient Employer: _____ Address _____

City _____ ST _____ ZIP _____ Phone _____

Referred by: (*check one*)

☐ Self ☐ Family ☐ Doctor ☐ Attorney ☐ Other _____

☐ Work Comp Case Mgr _____ Case Manager's Phone Number: _____

Primary Care Physician:

Name _____ Phone: _____ Fax: _____

Address: _____ City _____ ST _____ ZIP _____

Referring Physician

Name _____ Phone: _____ Fax: _____

Address: _____ City _____ ST _____ ZIP _____

INSURANCE INFORMATION

Primary Insurance Provider _____ Policy Holders Name: _____

Policy Holder's DOB _____ / _____ / _____ Policy Holder's SSN _____ - _____ - _____ Relationship to Patient _____

Secondary Insurance Provider _____ Policy Holders Name: _____

Policy Holder's DOB _____ / _____ / _____ Policy Holder's SSN _____ - _____ - _____ Relationship to Patient _____

Name of Guarantor _____

Guarantor's DOB _____ / _____ / _____ Guarantor's SSN _____ - _____ - _____ Relationship to Patient _____

Guarantor's Employer _____ Address _____

City _____ ST _____ ZIP _____ Phone _____

TODAY'S VISIT/HISTORY OF PRESENT ILLNESS

Describe the reason for your visit today: _____

_____

_____

Have you seen a physician for today's problem? ☐ Yes ☐ No

Who? _____

What was the diagnosis from the other physician? _____

_____

What tests/procedures did the other physician order?

☐ CAT Scan ☐ X-ray ☐ Bone Scan ☐ MRI ☐ Other _____

Is this problem …

the result of an accident? ☐ Yes ☐ No

Date of injury _____

work related? ☐ Yes ☐ No

involving attorney? ☐ Yes ☐ No

Date symptoms began _____

Describe any previous treatment for today's problem:

_____

_____

What are your symptoms? _____

Do the symptoms change with activity? Describe: _____

SOCIAL HISTORY

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **No. of Children:** _____ **Female Only: Are you pregnant?** ☐ Yes ☐ No

What is your occupation _____ **Hobbies/recreation:** _____

What sports do you play? _____ **Do you regularly wear a seatbelt?** ☐ Yes ☐ No

Some drugs, alcohol and tobacco can have a negative effect on anesthesia and healing.

Do you drink alcohol? ☐ Yes ☐ No

Type: ☐ Beer ☐ Wine ☐ Mixed Drinks

No. drinks: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ **Per**: ☐ Day ☐ Week ☐ Mo.

Have you ever had a problem with alcohol? ☐ Yes ☐ No

Do you currently use any of the following drugs?

☐ Marijuana ☐ Cocaine or Crack ☐ Heroin ☐ Meth

☐ Other _____

How often? ☐ Daily ☐ Weekly ☐ Occasionally

Do you use tobacco? ☐ Yes ☐ No ☐ Quit Date: _____ **Type of tobacco**: ☐ Cigarettes ☐ Cigars ☐ Chew

Cigarette Packs/day: ☐ ¼ ☐ ½ ☐ 1 ☐ 1-2+ **No. cigars day** _____ **Total length of use (in years):** _____

PAST MEDICAL HISTORY *Please check all that apply or check here if none apply, overall healthy:* ☐

Height _____ ft. _____ in. **Weight** _____ lbs. **Are you:** ☐ right handed ☐ left handed

- ☐ Anemia
- ☐ Ankle Swelling
- ☐ Anxiety/Panic Attacks
- ☐ Anesthesia Complications
  - ☐ *Malignant Hyperthermia*
- ☐ Arrhythmia
- ☐ Arthritis/Osteoarthritis
- ☐ Asthma/Lung Disease
- ☐ Bleeding Tendency
- ☐ Blindness/Vision Difficulty
- ☐ Blood Clots
- ☐ Blood Thinners _____
- ☐ Bone/Joint Infection
- ☐ Bruise Easily
- ☐ Bunions
- ☐ Cancer _____
  - ☐ *Chemo* ☐ *Radiation*
- ☐ Cardiac Problems
- ☐ Carpal Tunnel, Neuropathy
- ☐ Chest Pain, Angina
- ☐ Circulatory Problems
- ☐ Cirrhosis, Jaundice
- ☐ Claustrophobia
- ☐ Deafness or hearing trouble
- ☐ Depression
- ☐ Diabetes ☐ 1 ☐ 2
- ☐ Diverticulitis
- ☐ Emphysema or COPD
- ☐ Fainting/loss of consciousness
- ☐ Fatigue/Weakness
- ☐ Fevers
- ☐ Gall Stones
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack/MI
- ☐ Heart Condition (congenital)
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hypertension (High BP)
- ☐ Irritable Bowel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ *Dialysis* ☐ *No Dialysis*
- ☐ Liver Disease
- ☐ Lumbar Disk Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Morning Stiffness
- ☐ Multiple Sclerosis
- ☐ Muscle Spasms
- ☐ Muscle Tenderness
- ☐ Muscle Weakness
- ☐ Myasthenia Gravis
- ☐ Numb/Tingling hands/feet
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Parkinson's Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Poly/Fibromyalgia
- ☐ Renal Failure
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sickle Cell
- ☐ Skin Problems/Disorders
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Stroke/TIA
- ☐ TB (Tuberculosis)
- ☐ Thyroid High Low
- ☐ TMJ (Jaw locks or pops)
- ☐ Ulcers/Reflux/GERD
- ☐ Vascular/Circulatory
- ☐ Varicose Veins
- ☐ Vertigo

☐ Other _____

PAST SURGICAL HISTORY *Please check all that apply.* **Problems with Anesthesia?** ☐ Yes ☐ No

General Surgery

- ☐ Neurosurgery
- ☐ Tonsillectomy
- ☐ Adnoidectomy
- ☐ Thyroidectomy
- ☐ Cardica Cath
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ Thoracic/Lung Surgery
- ☐ Abdominal Surgery
- ☐ Appendectomy
- ☐ Transplant
- ☐ Joint Replacement
- ☐ Back Surgery
- ☐ Mastectomy
- ☐ Hysterectomy
- ☐ Cesarean Section
- ☐ Cholecystectomy
- ☐ Other:_____

Orthopedic Surgery

- ☐ ACL Reconstruction
- ☐ Arthroscopy (Circle Below)
- ☐ Ankle Left Right
- ☐ Elbow Left Right
- ☐ Hip Left Right
- ☐ Knee Left Right
- ☐ Shoulder Left Right
- ☐ Wrist Left Right
- ☐ Back Surgery
- ☐ Previous Fractures? _____
- ☐ Ankle Replacement Left Right
- ☐ Carpal Tunnel Rel Left Right
- ☐ Hip Replacement Left Right
- ☐ Knee Replacement Left Right
- ☐ Shoulder Replace. Left Right

CURRENT MEDICATIONS

List any medications you are currently taking including items such as aspirin, vitamins, laxatives, calcium supplements, over-the-counter medications, etc. If you need additional space, please write on back of this page. Thank you.

Name of Drug	Dosage	Frequency	How long have you taken this medication?	This medication has helped: *A Lot*	*Some*	*None*
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Pharmacy: Name _____ Location _____ Phone _____

ALLERGIES

Are you allergic to any drugs or food? ☐ Yes ☐ No (*Please list below*)

Name of Food or Drug	Reaction	Name of Food or Drug	Reaction

FAMILY MEDICAL HISTORY *Check problem and indicate who was diagnosed: Mother = M, Father = F, Sibling = S, Grandparent =G*

Disorder	Who	Disorder	Who
☐ Alcohol Liver Disease	☐ M ☐ F ☐ S ☐ G	☐ Cancer	☐ M ☐ F ☐ S ☐ G
☐ Bleeding Disorder	☐ M ☐ F ☐ S ☐ G	Type: _____	☐ M ☐ F ☐ S ☐ G
☐ Colon Polyps	☐ M ☐ F ☐ S ☐ G	Type: _____	☐ M ☐ F ☐ S ☐ G
☐ Diabetes 1 2	☐ M ☐ F ☐ S ☐ G	Type: _____	☐ M ☐ F ☐ S ☐ G
☐ GERD	☐ M ☐ F ☐ S ☐ G	Type: _____	☐ M ☐ F ☐ S ☐ G
☐ Heart Disease	☐ M ☐ F ☐ S ☐ G	Type: _____	☐ M ☐ F ☐ S ☐ G
☐ Stroke	☐ M ☐ F ☐ S ☐ G	☐ Collagen Disease	☐ M ☐ F ☐ S ☐ G
☐ Anesthetic Complications	☐ M ☐ F ☐ S ☐ G	☐ Scoliosis	☐ M ☐ F ☐ S ☐ G
☐ Rheumatoid Arthritis	☐ M ☐ F ☐ S ☐ G	☐ Hip Fracture	☐ M ☐ F ☐ S ☐ G
☐ Osteoarthritis	☐ M ☐ F ☐ S ☐ G		

PATIENT REVIEW OF SYSTEMS (Please check all the symptoms you are currently experiencing.)

CONSTITUTIONAL
- ☐ Fever
- ☐ Fatigue/Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ OTHER: _____

EYES
- ☐ Blurred Vision
- ☐ Failing Vision
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ OTHER: _____

ENT
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ OTHER: _____

CHEST
- ☐ Swelling
- ☐ Masses
- ☐ Pain
- ☐ OTHER: _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Defects
- ☐ Palpitations
- ☐ Skipping Heartbeats
- ☐ Murmurs
- ☐ OTHER: _____

RESPIRATORY
- ☐ Difficulty Breathing
- ☐ Chronic Coughing
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ History of TB
- ☐ TB Exposure
- ☐ OTHER: _____

GASTROINTESTINAL
- ☐ Appetite Loss
- ☐ Nausea (persistent)
- ☐ Vomiting
- ☐ Chronic Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ GI Bleed
- ☐ Ulcers/Reflux/GERD
- ☐ Blood in Stool
- ☐ Hepatitis
- ☐ OTHER: _____

GENITOURINARY
- ☐ Excess Urination
- ☐ Difficult Urination
- ☐ Frequent Urination (PM)
- ☐ Leakage of Urine
- ☐ Retention of Urine
- ☐ Passing Stones
- ☐ Pregnancy
- ☐ OTHER: _____

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Ankle Swelling
- ☐ Disturbance in walking
- ☐ Tingling Sensation
- ☐ OTHER: _____

NEUROLOGICAL
- ☐ Memory Loss
- ☐ Seizures
- ☐ Weakness
- ☐ Dizzy Spells
- ☐ Severe Headaches
- ☐ Difficulty Walking
- ☐ Stroke/TIA
- ☐ OTHER: _____

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ OTHER: _____

ENDOCRINE
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Thyroid Trouble
- ☐ OTHER: _____

LYMPHATIC
- ☐ Abnormal Bruising
- ☐ Bleeding Disorders
- ☐ HIV
- ☐ OTHER: _____

ALLERGY
- ☐ Latex Allergy
- ☐ Drug Allergies
- ☐ Recurrent Infections
- ☐ Adhesive bandages
- ☐ Anesthesia Complications
- ☐ Nickel (metal)
- ☐ Stainless Steel
- ☐ OTHER: _____

SKIN
- ☐ Skin Rash
- ☐ Itching
- ☐ Suspicious Lesions
- ☐ OTHER: _____

DIRECTIVES

Do you have living will or advanced directive? ☐ Yes ☐ No

Do we have this paperwork on file at KU Hospital? ☐ Yes ☐ No ☐ Don't know ☐ I will bring day of surgery

If you were unable to communicate, is there someone you would trust to make decisions for you? ☐ Yes ☐ No

Name: _____ **Relationship**: _____ **Phone**: (_____) _____

Do you have legal paperwork that says this person is your Power of Attorney? ☐ Yes ☐ No

Do we have this paperwork on file at KU Hospital? ☐ Yes ☐ No ☐ Don't know ☐ I will bring day of surgery

Do we need to arrange for an interpreter? ☐ Yes ☐ No **If yes, what language do you speak?** _____

Any religious or cultural beliefs that would prohibit you from receiving blood products? ☐ Yes ☐ No

I have reviewed this information. Faculty Signature _____

Date _____