# Oakton Urgent and Primary Care Center

## Health History Intake Form

**Patient Name:**_____ **Preferred Pharmacy:**_____

**Date of Birth:**_____ **Address:**_____

**Male** □ **Female** □ **Phone:**_____

**Previous Primary Care Physician (if any):**_____

**Phone:**_____ **Address:**_____

**Other Physicians involved in your care:**_____

_____

**Allergies** (Medication/Food, indicate reaction): □ None

_____

_____

_____

**Medication List:** (Please list name/dose/frequency if known)

_____

_____

_____

_____

_____

_____

_____

**Family History:** (please indicate deceased or alive, medical issues and age)

Father:_____

Mother:_____

Siblings: Sister(s):_____

Brother(s):_____

Grandparents:_____

Aunts/Uncles:_____

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**Habits:**
Alcohol: ◻ None ◻ Yes: How many drinks/day _____frequency/week _____
Tobacco: ◻ None ◻ Yes: _____ How many/day _____ since_____
Other Recreational Drugs: ◻ None ◻ Yes: What kind_____
Do you always wear a seatbelt? ◻ Yes ◻ No
Do you exercise? ◻ Yes ◻ No If yes, how often & what kind?_____
_____

**Social History:**
Work: ◻ Employed ◻ Unemployed ◻ Retired ◻ Disabled
Current Occupation: _____

**Marital Status:** ◻ Married ◻ Single ◻ Divorced ◻ Domestic Partner
Sexual Orientation: ◻ Heterosexual ◻ Homosexual ◻ Bisexual
Contraception: ◻ Yes ◻ No Protected: ◻ Yes ◻No

Children (age):_____
Pets:_____

**Past Surgical History (indicate date if known)**

◻ None
◻ Cataracts_____
◻ LASIK_____
◻ Tonsillectomy_____
◻ Thyroidectomy_____
◻ Adenoidectomy_____
◻ Coronary Bypass_____
◻ Cardiac Stents_____
◻ Pacemaker_____
◻ Heart Valve_____
◻ Gall Bladder_____
◻ Appendectomy_____
◻ Bowel/Stomach Resection_____
◻ Hemorrhoidectomy_____
◻ Bariatric surgery_____
◻ Hysterectomy_____
◻ Endoscopy_____
◻ Colonoscopy_____
◻ Hernia_____
◻ Spinal Surgery_____
◻ Tubal Ligation_____
◻ Bladder surgery_____
◻ Prostate surgery/resection_____
◻ C-Section_____
◻ Orthopedic/joints_____
◻ Other_____
_____

**Over Night in Hospital?**
◻ Yes ◻ No For what reason? _____
_____
_____

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## Past Medical History:

Head Aches ☐ Yes ☐ No Date: _____
Stroke ☐ Yes ☐ No _____
Seizures ☐ Yes ☐ No _____
Pneumonia ☐ Yes ☐ No _____
Diabetes (Type 1 or Type 2) ☐ Yes ☐ No _____
Thyroid Disease (Low or High) ☐ Yes ☐ No _____
Glaucoma ☐ Yes ☐ No _____
Macular Degeneration ☐ Yes ☐ No _____
Hearing Loss ☐ Yes ☐ No _____
High Blood Pressure ☐ Yes ☐ No _____
Blood Clots ☐ Yes ☐ No _____
- ☐ Pulm Emboli (lung clots) ☐ Yes ☐ No _____
- ☐ DVT (leg clots) ☐ Yes ☐ No _____

Heart Burn, Reflux ☐ Yes ☐ No _____
Stomach Ulcers ☐ Yes ☐ No _____
Heart Disease ☐ Yes ☐ No _____
- ☐ Coronary Disease ☐ Yes ☐ No _____
- ☐ MI/heart attacks ☐ Yes ☐ No _____
- ☐ Congestive Heart Failure ☐ Yes ☐ No _____
- ☐ Atrial Fibrillation ☐ Yes ☐ No _____
- ☐ Angina ☐ Yes ☐ No _____
- ☐ Valve Disorder ☐ Yes ☐ No _____

High Cholesterol ☐ Yes ☐ No _____
Gastrointestinal Bleeding ☐ Yes ☐ No _____
Hepatitis (A, B, C) ☐ Yes ☐ No _____
HIV / AIDS ☐ Yes ☐ No _____
Chronic Wounds ☐ Yes ☐ No _____
Cancer (type) ☐ Yes ☐ No _____
Urinary Tract Infections ☐ Yes ☐ No _____
Incontinence ☐ Yes ☐ No _____
Kidney Stones ☐ Yes ☐ No _____
COPD (Emphysema, Bronchitis) ☐ Yes ☐ No _____
Asthma ☐ Yes ☐ No _____
Depression ☐ Yes ☐ No _____
Bipolar Disorder ☐ Yes ☐ No _____
Anxiety ☐ Yes ☐ No _____
Fibromyalgia ☐ Yes ☐ No _____
Chronic Fatigue Syndrome ☐ Yes ☐ No _____
Arthritis ☐ Yes ☐ No _____
Gout ☐ Yes ☐ No _____
Osteoporosis ☐ Yes ☐ No _____
Prostate Disease ☐ Yes ☐ No _____
Breast Disease ☐ Yes ☐ No _____
Erectile Dysfunction ☐ Yes ☐ No _____

Other _____

Oakton Urgent Care Center
EMERGENCY & PRIMARY CARE SERVICES

DAVID G. ALLINGHAM, M.D.
MEDICAL DIRECTOR

2915 HUNTER MILL ROAD, STE 11
OAKTON, VA 22124
Telephone 703-255-1190, FAX 703-255-1193

## PATIENT REGISTRATION

DATE COMPLETED:

| Patients name: (Please Print) | FIRST | M.I. | LAST | E-MAIL This will be used for ALL balance BILLING |
|---|---|---|---|---|
| SEX O Male O Female | DATE OF BIRTH | AGE | ALLERGIES TO MEDS: | SOCIAL SECURITY NUMBER: |
| ADDRESS Street | City | State | Zip | HOME PHONE # CELL PHONE # |
| MARITAL STATUS o Married o Divorced o Single | OCCUPATION or STUDENT GRADE | | | WORK PHONE # |
| EMPLOYER or SCHOOL NA ME & ADDRESS Street | City | State | Zip | |

## CONDITION INFORMATION

| WHAT PROBLEM BROUGHT YOU HERE? | DATE OF ONSET OF SYMPTOMS | IS PATIENT'S CONDITION RELATED TO: o EMPLOYEMENT o AUTO ACCIDENT o N/A |
|---|---|---|
| IF THIS IS A WORK RELATED PROBLEM, PROVIDE SUPERVISOR'S NAME & PHONE # | LAST TETANUS SHOT | LAST TUBERCULOSIS SCREENING |

Pharmacy Of Choice -

## PRIMARY INSURANCE *if no insurance please check o*

**SECONDARY INSURANCE-PLEASE PRESENT CARD TO RECEPTIONIST**

| INSURANCE COMPANY NAME OR MEDICARE INFORMATION O SEE CARD | POLICY NUMBER | *POLICY HOLDER'S NAME:* | *HOME PHONE ( )* |
|---|---|---|---|
| GROUP NUMBER | INSURED'S ADDRESS STREET CITY STATE ZIP | SOCIAL SECURITY #: | |
| PATIENT'S RELATIONSHIP TO INSURED | DATE OF BIRTH | INSURANCE COMPANY PHONE NUMBERS | *EMPLOYER'S NAME & PHONE NUMBER* |

## PERSON FINANCIALLY RESPONSIBLE (If different from patient)

| NAME | | PATIENT'S RELATIONSHIP | HOME PHONE # |
|---|---|---|---|
| ADDRESS: Street City | State Zip | SOCIAL SECURITY NUMBER | WORK PHONE # |

## PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING MEDICAL ILLNESSES AND WHEN YOU WERE DIAGNOSED

*o DIABETES o HYPERTENSON o THYROID DISEASE o HEART DISEASE o ARTHRITIS o DEPRESSION o OTHER_____*

## MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING PAIN MEDICINES, VITAMIONS, OTC, AND BIRTH CONTROL.

| NAME OF MEDICATION: | DOSE: | HOW OFTEN: | REASON FOR TAKEN: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## CONSENT AND INSURANCE AUTHORIZATION

I hereby authorize Oakton Urgent Care Center (OUCC) to apply for benefits on my behalf or covered services rendered by them. I request payment from participating insurance carriers to be made directly to the above named group. If OUCC does not participate with the insurance, I will accept OUCC payment arrangement at the time of service. If I am paying privately, payment in full is due at time of service. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information including medical information to any insurance carrier or me or above. This authorization may be revoked by my insurance carrier or me at any time in writing. I understand and agree to be responsible for any portion of these claims that for any reason is not covered by my insurance and balance remaining is due within 60 days. I understand that legal fees incurred to collect this claim are my responsibility as well as any service charges assessed to accounts with returned checks or invalid credit card purchases. I have read all the information above. I certify this information is true and correct to the best of my knowledge.

**I GIVE OAKTON URGENT CARE PERMISSION TO RENDER CARE.**

X_____ X_____

*Signature (Responsible Party)* *Date* *Patient (Parent or legal guardian if patient is under 18)* *Date*

I understand, HIPA, THE PRIVACY ACT (posted at entrance) X_____ INTIAL