THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

NEW PATIENT INFORMATION CAPITAL UNIVERSITY

Please arrive at the Kline Health Center (2311 E. Main St.) promptly, allowing ample time for parking, registration and X-rays (if applicable); 20-30 minutes prior to your appointment time is recommended. We request that you call 614-236-6114 to reschedule if you are unable to arrive on time.

Please bring these items:

- Completed registration forms from this packet; present these at the front desk check-in
- If applicable (check with your insurance provider), a referral from your primary care physician to see a specialist
- Insurance card, photo ID and co-payment

OFFICE POLICIES

Thank you for choosing The Ohio State University Wexner Medical Center for your healthcare needs. We realize that you have a choice in medical providers and we appreciate your business. Please review these policies to help ensure an optimal patient experience:

- Bring your insurance card to every visit so that we can verify coverage and eligibility and process your claim.
- At check-in, inform us if you have any changes to your name, address, phone number, insurance or other demographic information so we may readily contact you if questions or issues arise.
- If you find yourself running late, please call us at 614-236-6114. As a courtesy to our other patients, we will consult with the physician and may request that your visit be rescheduled.

CONTACT PREFERENCES

I wish to be contacted in the following manner: *(PLEASE CHECK ALL THAT APPLY)*		OK to leave message with detailed information	Leave message with call-back number only
☐ Home phone	____________	☐	☐
☐ Work phone	____________	☐	☐
☐ Cell phone	____________	☐	☐
☐ Fax to	____________		
☐ Mail to	____________		

I would like the following individuals to be involved in my care, and agree that my treatment information may be shared with them:

Spouse ____________ Adult children ____________

My parent(s) ____________ Other ____________

Any other additional instructions that apply: ____________

Signature ____________ Date ____________

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PATIENT DATA FORM

Name: ______________________________ Date of Birth: ____________ Today's Date: ____________

MEDICAL HISTORY

Do you have, or have you had, any of the following?

	Yes	No
Chicken Pox	☐	☐
Rheumatic Fever	☐	☐
Mumps	☐	☐
Measles	☐	☐
German Measles	☐	☐
Scarlet Fever	☐	☐
Shingles	☐	☐
Tuberculosis	☐	☐
COPD / Emphysema	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Myocardial infarction / Heart Attack	☐	☐
Diabetes	☐	☐
Stomach Ulcers	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Kidney Disease	☐	☐
Thyroid Disease	☐	☐
Cancer (Type _______________)	☐	☐
Depression	☐	☐
Stroke	☐	☐
Epilepsy / Seizures	☐	☐
Glaucoma	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
HIV	☐	☐
Hepatitis A, B or C	☐	☐

Are you currently having problems with any of the following?

	Yes	No
Fever	☐	☐
Blurred or Double Vision	☐	☐
Loss of Vision	☐	☐
Problems Swallowing	☐	☐
Sore Throat	☐	☐
Earache	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Shortness of Breath	☐	☐
Persistent Cough	☐	☐
Coughing Up Blood	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Nausea or Vomiting	☐	☐
Abdominal Pain	☐	☐
Blood in Stool or Black Stool	☐	☐
Painful Urination	☐	☐
Blood in Urine	☐	☐
Convulsions	☐	☐
Headaches	☐	☐
Depression	☐	☐
Joint Pain	☐	☐
Muscle Pain	☐	☐
Hives or Skin Rash	☐	☐

Hospitalizations and Surgeries (Denote right or left side of body, if applicable)	**Year**

Allergies (drug, food and/or environmental)	**Reaction**

Medication, Vitamin or Herb Use	**Dosage/ Frequency**

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PATIENT DATA FORM PAGE 2 of 2

FAMILY HISTORY

Family Member	Age	Check if alive	Please List Any Significant Health Problems
Mother		☐	
Father		☐	
Sister		☐	
Brother		☐	
		☐	
		☐	

SOCIAL HISTORY

Do you use tobacco products? ☐ Never ☐ Quit (How long ago? ________) ☐ Yes (Type/how many per day?______________)

Have you used recreational substances within the last 2 years? ☐ No ☐ Yes (Please identify: ☐ Marijuana ☐ Cocaine ☐ Other)

Do you drink alcohol? ☐ No ☐ Yes (# of drinks per week ________)

PROVIDER AND PHARMACY INFO

Preferred pharmacy (name and location) ____

Family physician (name and phone) ____

Cardiologist, if applicable (name and phone)____