Little Company of Mary

Providence Little Company of Mary Medical Center
Emergency Patient Information Sheet
PLEASE PRINT

Patient's Last Name_____ First Name_____Middle Initial_____

Patient's Date of Birth_____/_____/_____ Age_____ Sex: F M Marital Status: S M Seperated D W Patient's Place of Birth_____

Patient's Social Security Number_____-_____-_____ Patient's Religious Preference:_____ Primary care doctor_____

Patient's Home Address_____Apt or Unit number_____ City_____

State_____ Zip_____ Patient's Home Phone Number _____-_____-_____ Patient's Cell Phone Number _____-_____-_____

Emergency Contact Information Last name_____First name_____Home Phone_____-_____-_____

Cell Phone_____-_____-_____ Work Number_____-_____-_____ Emergency Contact's relationship to the patient:_____

Alternate Contact, please list a person that does not live with the patient. Last Name_____ First Name_____

Home Phone _____-_____-_____ Cell Phone_____-_____-_____ Alternate Contacts Relationship to the patient:_____

Does the patient have any allergies to medications, food, latex or iodine? YES NO If YES please list allergies:_____

_____

Does the patient have an Advanced Directive or Durable Power of Attorney for Health Care? YES NO Patient's Primary Language_____

If patient is a child/minor please complete the following information:

Patient's Mother's Last Name_____First Name_____

Address, if different from patient_____Apt or Unit number_____

City_____ State_____ Zip_____ Date of Birth_____/_____/_____

Home Phone Number_____-_____-_____ Work Number_____-_____-_____ Cell Number_____-_____-_____

Patient's Father's Last Name_____First Name_____

Address, if different from patient_____Apt or Unit number_____

City_____ State_____ Zip_____ Date of Birth_____/_____/_____

Home Phone Number_____-_____-_____ Work Number_____-_____-_____ Cell Number_____-_____-_____

Please return to the front desk when complete. Thank you for choosing Providence Little Company of Mary Medical Center.

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Emergency Department
Medical History

Name_____ Date_____

PRIMARY CARE PHYSICIAN: _____
CARDIOLOGIST: _____
OTHER TREATING PHYSICIANS: _____

PAST MEDICAL HISTORY:

Diabetes:	yes☐	no☐
High blood pressure:	yes☐	no☐
High cholesterol	yes☐	no☐
Coronary artery disease	yes☐	no☐
CHF	yes☐	no☐
Cancer	yes☐	no☐
Asthma/COPD	yes☐	no☐
Arthritis	yes☐	no☐
Stroke	yes☐	no☐
Kidney disease	yes☐	no☐

OBSTETRIC/GYNECOLGIC HISTORY:
Pregnant: yes☐ no☐ not sure☐
If yes, how many weeks?_____
Last menstrual period:_____
Number of children:_____
Number of miscarriages:_____
Number of abortions:_____

Other Diseases (please list)
_____
_____

PAST SURGERIES: (please list all surgeries with approximate dates)
_____
_____

List all medications you are taking: (or supply an accurate list)
_____
_____
_____
_____

List all allergies to medications:
_____

FAMILY HISTORY: (List any significant family medical problems, ie, cancer, heart attacks, genetic disorders, strokes, etc.)
_____

SOCIAL HISTORY:

Do you use tobacco products?	yes☐	no☐	Packs per week: _____
Do you drink alcohol?	yes☐	no☐	Drinks per day: _____
Do you use illicit drugs?	yes☐	no☐	What type?: _____

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Emergency Department
Review of Systems

Name_____ Date_____

Please check off all symptoms you have had recently.

General/Constitutional:	Yes	No
Fever	☐	☐
Chills	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐
Loss of energy	☐	☐

Eyes:		
Blurred vision	☐	☐
Eye pain	☐	☐
Vision loss	☐	☐
Discharge	☐	☐

Ears, Nose, Throat:		
Earache	☐	☐
Nasal congestion	☐	☐
Nosebleeds	☐	☐
Sore throat	☐	☐
Toothache	☐	☐
Recent dental work	☐	☐

Respiratory:		
Shortness of breath	☐	☐
Cough	☐	☐
Wheezing	☐	☐
Phlegm production	☐	☐

Cardiovascular:		
Chest pain	☐	☐
Palpitations	☐	☐
Fainting	☐	☐
Heart problems	☐	☐

Gastrointestinal:		
Abdominal pain	☐	☐
Nausea or Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody stools	☐	☐

Genitourinary:	Yes	No
Painful urination	☐	☐
Frequent urination	☐	☐
Bloody urine	☐	☐
Vaginal bleeding	☐	☐
Vaginal discharge	☐	☐

Lymphatic/Hematologic:		
Swollen lymph glands	☐	☐
Easy bleeding	☐	☐
Easy bruising	☐	☐

Musculoskeletal:		
Joint pain/arthritis	☐	☐
Muscle pain/cramps	☐	☐
Recent trauma	☐	☐

Skin:		
Rash	☐	☐
Abscesses	☐	☐
Itchiness	☐	☐
Infections	☐	☐

Neurologic:		
Headache	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Numbness	☐	☐
Dizziness	☐	☐

Endocrine:		
Excessive thirst	☐	☐
Excessive urination	☐	☐
Generalized weakness	☐	☐

Psycho-social:		
Depression	☐	☐
Anxiety	☐	☐
Suicidal thoughts	☐	☐