HAND & UPPER EXTREMITY CENTER, PA
OLAYINKA OGUNRO, M.D., F.A.C.S
CHARITY OGUNRO, M.D.

PATIENT INFORMATION SHEET
THIS FORM MUST BE FILLED OUT WITH ALL APPLICABLE INFORMATION
NOTE: PATIENT IS RESPONSIBLE FOR ALL BILLS

PLEASE PRINT

Date: ___________________________________

Patient's Name: ___________________________________ SS #: ___________________________

Single: __________ Married: __________ Separated: __________ Widow: __________

Address: ___________________________________ City: __________ ST: ______ ZIP: ________

Date of Birth: ________________ Age: ________ Sex: __________ Hm. Phone: ________________

Weight: ________ Height: ________ Pharmacy Name & No: ______________________________

Cell #: ____________________ E-Mail Address: ______________________________

Race: White, Hispanic, Asian, African-American, Other ______________ Ethnicity: ________________

Patient's Responsible Party's Employer: ______________________________________

Address: ___________________________________ City: __________ ST: ______ ZIP: ________

Position: ___________________________________ Work Phone: ____________________

Spouse Name: ______________________________ Employer: ______________________

If child, parent's name: ___________________________ SS #: ______________________

Nearest Relative: ______________________________ Phone #: ____________________

Insured's Name: ______________________________ SS #: ______________________

Insured's D.O.B.: ______________________

Insurance Co: ___________________________________ Phone #: ____________________

Group #: ________________________ Cert. or Policy #: ______________________________

Drivers License #: ______________________________ Referred By: ____________________

On the job injury: Yes: ____________________ No: ____________________

Claim Number: ______________________________ Date of Injury: ____________________

Chief Complaint (Reason for visit): ____

Present illness, include dates and previous treatment:____

Family History:____

Past Medical History (diabetes, hypertension, HIV, heart problems, gastric ulcers, etc.): ______________________

Past Surgeries: ____

*****Any Blood Borne Illness (i.e. HIV, Hepatitis C, Syphilis) Yes _____________ No ______________**

Review of systems: (Please circle all that apply)
General: chills, fever, fatigue, night sweats and weight loss
HEENT: hearing problems, ear/nose/throat pain, congestion, runny nose, nose bleeds, hoarseness and dental problems
Cardiovascular: chest pain, palpitations, increased heart rate, orthopnea, and edema.
Respiratory: cough, dyspnea, and coughing up blood
Gastrointestinal: abdominal pain, heartburn, constipation, diarrhea and stool changes
Urinary: urgency, frequent urination, painful urination, blood in the urine, waking up at night to urinate, incontinence, stones, infection
Vascular: leg edema, leg cramping, varicose veins, thromboses/emboli
Musculoskeletal: muscle weakness, pain, joint stiffness, instability, redness, swelling, gout, except for areas of symptoms.
Neurologic: loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, seizures
Endocrine: heat/cold intolerance, excessive sweating, polyuria, polyphagia, excessive thirst

Personal History:

Use of drugs: Yes:____________ No:_____________ How much:___________________________

Do you smoke: Yes:____________ No:_____________ How much:___________________________

Do you drink alcohol: Yes:____________ No:____________ How much:________________________

Current Medications You Are Taking: ____

Are you taking: Diet Pills, Vitamins or Herbs:____

Allergies to medications:____

Are you Right Handed:________________________ or Left Handed:_____________________________

Type of work you do? ____

Describe in detail your job duties: Example…Pushing, Pulling, Keying, Bending, Lifting (How many lbs?) and Typing.

I hereby authorize my insurance benefits to be paid to the physician and I do realize I am financially responsible for non-covered services. I also authorize the physician to release any medical information and records required in the processing of claims.

_______________________________________ _______________________________

Patient's Signature Date