Missouri Delta
Physician Services

Dear New Patient,

Thank you for choosing Missouri Delta Physician Services!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐Health History Form ☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

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MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION
(to be completed by patient) **Date:** _____

Name: First _____ Middle _____ Last _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____ Race _____ Religion _____

Social Security Number _____ Maiden/Other Name _____ Family Doctor _____

Patient Address _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Email Address _____

Patient Employer _____

Address: _____

City/State/Zip _____ Phone _____

Preferred Pharmacy _____

Next of Kin

Spouse/Father/Mother Name _____ D.O.B. _____

(Spouse or Parent if Patient is under 18 years of age)

S.S.N.# _____ Cell Phone Number _____

Address if different from above _____

Spouse/Parent Employer _____

Address _____

City/State/Zip _____ Phone _____

Closest Relative NOT Living With You

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Person to Notify (other than Next of Kin)

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

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Fred Uthoff, DO

Health History Form

Patient Name_____ **Date of Birth**_____ **Today's Date**_____

Name of your prior Primary Care Provider: _____

Main reason for Today's visit: _____

Allergies to medication/food/latex: Please provide name of allergy and reaction: □No allergies

_____
_____

Medications: Prescription & over-the-counter.
□No current medications

Medication Dose

_____
_____
_____
_____
_____
_____
_____
_____
_____

*May use back to write additional medications or attach copy

Personal Medical History: Have you have had any of the following medical conditions.

__High Blood Pressure
__Heart Disease
__Stroke
__Asthma/COPD
__Diabetes
__High Cholesterol
__Thyroid Problem
__Kidney Disease
__Cancer, Type:_____
__Other: please describe:_____
Date of last colonoscopy: _____
Date of last Dexa Scan: _____

For Women:
Date of last pap smear: _____
Date of last mammogram: _____

Surgical History: Please indicate whether you have had any of the following surgeries.

__Tonsillectomy
__Hysterectomy
__Angioplasty
__Appendectomy
__Gallbladder
__ Other: please describe:_____

Family History: Please indicate whether you have a blood relative with the following.

__Heart disease
__High blood pressure
__Bleeding disorder
__Mental illness
__Stroke
__Migraines
__Diabetes
__Cancer: type:_____
__Other: Please describe:_____

Social History: Please indicate whether you do the following.

__Smoke Cigarettes:
if yes, packs per day_____ for how many years_____
__Smokeless tobacco
if yes, how much per day_____ for how many years_____
__Drink Alcohol
If yes, what and how often_____
___Recreational Drug Use
If yes, what and how often_____

For Men:
Date of last prostate exam: _____

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Health History Form

Patient Name_____ **Date of Birth**_____ **Today's Date**_____

Current Problems: Please indicate if you are having or have had any of the following problems.

__ Fever
__ Fatigue
__ Night Sweats
__ Weight gain
__ Weight loss

__ Ear pain
__ Ear drainage
__ Hearing loss
__ Eye discharge
__ Eye pain
__ Visual changes
__ Nasal drainage
__Sinus drainage
__ Sore throat

__ Cough
__ Chronic cough
__ TB exposure
__ Shortness of breath
__ Wheezing

__ Chest pain
__ Swelling/edema
__ Palpitations
__ History of blood clots

__ Abdominal pain
__ Blood in stools
__ Changes in stool
__ Constipation
__ Diarrhea
__ Heartburn
__Loss of appetite
__ History of ulcers
__ Nausea
__ Vomiting

__ Food allergies
__ Seasonal allergies

__ Dysuria
__ Hematuria
__ Polyuria
__ Slow urinary stream
__ Urinary incontinence
__ Urinary retention
__ Sexual dysfunction
__ Vaginal or penile discharge
__ Sexually transmitted disease

__ Heat/Cold intolerance
__ Increased thirst
__ Increased urination
__ Hair loss

__ Dizziness
__ Extremity weakness
__ Numbness/tingling
__ Trouble walking
__ Headache
__ Memory loss
__ Seizures

__ Anxiety
__ Depression
__ Insomnia

__ Itchy skin
__ Mole changes
__ Rash
__ Poor wound healing
__ Dry skin

__ Back pain
__ Neck pain
__ Joint pain
__ Muscle weakness

__ Easily bleed
__ Easy bruising
__ Swollen lymph nodes
__ Weakened immune system

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: _____

Date:_____

□ Patient was unable /unwilling to sign acknowledgment.

Reason: _____

Staff initials: _____

Date: _____

Time: _____

Below is a list of people that may receive full disclosure of my medical information:

_____

_____

_____

Copy of Notice was included in patient's Admission Information Packet