

Westview Health Clinic  
3140 W Hayes  
Clinton OK 73601  
Telephone:580-323-1937 Fax: 580-323-1156

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### Patient Authorization Form

Patient Name: \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Street Address (if different than mailing): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Message: Yes \_\_\_\_\_ No \_\_\_\_\_ Message: Yes \_\_\_\_\_ No \_\_\_\_\_ Message: Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Message: Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

Is this visit related to Workers Comp? \_\_\_\_\_ Or any other type of accident? \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

### **\*\*\*Copy of Insurance Cards will be kept in Patient Files\*\*\***

#### **Benefits Assignment**

I hereby authorize the assignment of benefits (payments) directly to Kristy R. Baker ARNP/ Westview Health Clinic for all my insurance or cash claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles, non-covered services, and cash pay amounts are due at the time of service.

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

#### **Records Release**

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgment of Receipt of this Notice**

Westview Health Clinic is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:  
Westview Health Clinic

Name of Patient (PRINT) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

In accordance with the HIPPA guidelines this practice is authorized to discuss my medical information with the following individuals.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Consent for Examination**

I will be seen by a Nurse Practitioner who has acquired advanced education, special knowledge, and skills in the evaluation, diagnosis, treatment, education, risk assessment, health promotion, case management, coordination of care, and counseling in the primary care of adults.

\_\_\_ I, \_\_\_\_\_, hereby request that the Nurse Practitioner examine and treat me.

\_\_\_ I, \_\_\_\_\_, hereby request that the Nurse Practitioner examine and treat the dependent in my care, \_\_\_\_\_.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Receptionist \_\_\_\_\_

Date \_\_\_\_\_

# Medical History Questionnaire

(Please fill in all circles completely)

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Are you allergic to any medications? (If yes, list meds and reactions below)  Yes  No Are you Pregnant?  Yes  No

Please list below current medications you are taking (including prescriptions, over the counter meds, vitamins, herbal supplements):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_  
7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_

## Have you ever had a history of:

I have no history of significant medical problems  Yes

- |                     |                           |                     |                           |                    |                           |
|---------------------|---------------------------|---------------------|---------------------------|--------------------|---------------------------|
| AIDS                | <input type="radio"/> Yes | Emphysema           | <input type="radio"/> Yes | Mononucleosis      | <input type="radio"/> Yes |
| Alcoholism          | <input type="radio"/> Yes | Epilepsy (Seizures) | <input type="radio"/> Yes | Multiple Sclerosis | <input type="radio"/> Yes |
| Asthma              | <input type="radio"/> Yes | Glaucoma            | <input type="radio"/> Yes | Pneumonia          | <input type="radio"/> Yes |
| Anemia              | <input type="radio"/> Yes | Gout                | <input type="radio"/> Yes | Prostate Problems  | <input type="radio"/> Yes |
| Anorexia            | <input type="radio"/> Yes | Heart Disease       | <input type="radio"/> Yes | Psychiatric Care   | <input type="radio"/> Yes |
| Arthritis           | <input type="radio"/> Yes | Heart Attack        | <input type="radio"/> Yes | Stroke             | <input type="radio"/> Yes |
| Bleeding Disorder   | <input type="radio"/> Yes | Hepatitis           | <input type="radio"/> Yes | Suicide Attempt    | <input type="radio"/> Yes |
| Breast Lump         | <input type="radio"/> Yes | Herpes              | <input type="radio"/> Yes | Thyroid Problems   | <input type="radio"/> Yes |
| Bronchitis          | <input type="radio"/> Yes | High Cholesterol    | <input type="radio"/> Yes | Tonsillitis        | <input type="radio"/> Yes |
| Bulimia             | <input type="radio"/> Yes | HIV Positive        | <input type="radio"/> Yes | Ulcers             | <input type="radio"/> Yes |
| Cancer              | <input type="radio"/> Yes | Kidney Disease      | <input type="radio"/> Yes | Vaginal Infection  | <input type="radio"/> Yes |
| Chemical Dependency | <input type="radio"/> Yes | Liver Disease       | <input type="radio"/> Yes | Venereal Disease   | <input type="radio"/> Yes |
| Diabetes            | <input type="radio"/> Yes | Migraines           | <input type="radio"/> Yes |                    |                           |

List any other diseases or condition: \_\_\_\_\_

Have you had surgery in the last 3 months?  Yes  No Have you ever had skin cancer surgery?  Yes  No

## Social History

- Do you use alcohol?  Yes  No  
Have you ever used alcohol?  Yes  No  
Do you use tobacco?  Yes  No  
Have you ever used tobacco?  Yes  No  
Do you use drugs?  Yes  No  
Have you ever used drugs?  Yes  No  
Do you use caffeine?  Yes  No  
Have you ever used caffeine?  Yes  No  
Do you have children?  No  1  2  3  4 More: \_\_\_\_\_  
What is your marital status?  Single  Married  Divorced  Separated  Widowed  
What is your occupation? \_\_\_\_\_

## Family Medical History

- |                     |                            |                              |                              |                                 |                                  |                                   |                              |                                       |
|---------------------|----------------------------|------------------------------|------------------------------|---------------------------------|----------------------------------|-----------------------------------|------------------------------|---------------------------------------|
| Arthritis           | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Asthma              | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Cancer              | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Diabetes            | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Heart Disease       | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Stroke              | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| High Blood Pressure | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Chemical Dependency | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Thyroid Disease     | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |
| Depression          | <input type="radio"/> None | <input type="radio"/> Mother | <input type="radio"/> Father | <input type="radio"/> Sister(s) | <input type="radio"/> Brother(s) | <input type="radio"/> Daughter(s) | <input type="radio"/> Son(s) | <input type="radio"/> Extended Family |

# Comprehensive Review of Systems

(Please fill in all circles completely)

Name: \_\_\_\_\_

## Constitutional

weight change  Yes  No  
loss of appetite  Yes  No  
fever  Yes  No  
weakness  Yes  No  
night sweats  Yes  No  
depression  Yes  No  
Insomnia  Yes  No

## Dermatology

suspicious lesions  Yes  No  
rash  Yes  No  
itching  Yes  No  
dry skin  Yes  No  
hives  Yes  No  
hair loss  Yes  No  
lumps  Yes  No

## ENT

nose bleeds  Yes  No  
change in voice  Yes  No  
sore throat  Yes  No  
difficulty swallowing  Yes  No  
sinus problems  Yes  No

## Respiratory

shortness of breath  Yes  No  
chest tightness  Yes  No  
cough  Yes  No  
wheezing  Yes  No  
congestion  Yes  No

## Gastroenterology

blood in stool  Yes  No  
diarrhea  Yes  No  
vomiting  Yes  No  
constipation  Yes  No  
nausea  Yes  No  
abdominal pain  Yes  No  
change in bowel habits  Yes  No

## Psychology

depression  Yes  No  
high stress  Yes  No  
mood swings  Yes  No  
suicidal ideation  Yes  No  
obsessive-compulsive tendencies  Yes  No

## Neurology

headache  Yes  No  
tingling/numbness  Yes  No  
seizures  Yes  No  
dizziness  Yes  No  
focal weakness  Yes  No  
nervousness  Yes  No

## Ophthalmology

eye irritation  Yes  No  
drainage from eyes  Yes  No  
blurring of vision  Yes  No

## Genitourinary Female

Premenstrual Syndrome  Yes  No  
infertility  Yes  No  
dysmenorrhea  Yes  No  
frequent yeast infections  Yes  No  
vaginal itching  Yes  No  
intermenstrual bleeding  Yes  No  
pelvic pain  Yes  No  
sexual activity  Yes  No  
irregular periods  Yes  No  
abnormal vaginal discharge  Yes  No  
hot flashes  Yes  No

## Hematology

easy bruising  Yes  No  
swollen glands  Yes  No  
fatigue  Yes  No

## Endocrinology

excessive thirst  Yes  No  
excessive sweating  Yes  No  
excessive urination  Yes  No  
cold intolerance  Yes  No  
heat intolerance  Yes  No

## Allergy

Runny nose  Yes  No  
scratchy throat  Yes  No  
itchy eyes  Yes  No  
sneezing  Yes  No  
ear fullness  Yes  No  
stuffy nose  Yes  No  
cough  Yes  No

## Musculoskeletal

joint stiffness  Yes  No  
leg cramps  Yes  No  
joint pain  Yes  No  
joint swelling  Yes  No  
back pain  Yes  No  
neck pain  Yes  No  
muscle aches  Yes  No

## Urology

difficulty urinating  Yes  No  
blood in urine  Yes  No  
urinary urgency  Yes  No  
frequent urination  Yes  No  
urinary incontinence  Yes  No

## Cardiology

palpitations  Yes  No  
chest pain  Yes  No  
high blood pressure  Yes  No  
poor circulation  Yes  No  
swelling  Yes  No