Personal Data

Thank you for allowing us to participate in your healthcare! Please take a few moments to complete this form. Your healthcare provider will review this information during your visit. Filling out all sections will help us to better serve your health care needs.

Patient's Name: ______________________ **Date of Birth:** ______________ **Chart/Acct #** ____________

Preferred language spoken? ☐ English ☐ Spanish ☐ Other ______________________

Last grade of education completed ______________________

Are there any issues that may interfere with your appointments or medical care? ☐ Cost ☐ Memory ☐ Transportation

How can your healthcare provider best assist with your learning needs relative to your care?
☐ Audio/Video ☐ Written Material ☐ Discussion with your healthcare provider or nurse

☐ Yes ☐ No Do you depend on people living with you for personal care? If yes, what type of care? (Ex: bathing, dressing, mobility, etc.) ______________________

☐ Yes ☐ No Have you fallen in the last 12 months or do you have concerns regarding falls or home safety? If yes, please explain: ______________________

☐ Yes ☐ No Are there any cultural or religious beliefs that your health care provider should be aware of that would be helpful in your health care? If yes, please explain: ______________________

☐ Yes ☐ No Do you have any nutritional restrictions, needs or concerns? If yes, please list them: ______________________

☐ Yes ☐ No Do you have regular dental check ups? Name of your dentist: ______________________

☐ Yes ☐ No Have you been treated for pain in the past six (6) months to one (1) year? If yes, please explain what pain you were treated for (such as headache, back pain, etc.). ______________________
Which method seems to work the best for your pain? ______________________

☐ Yes ☐ No Do you have any history of mental, emotional, behavioral problems or depression? If yes, explain briefly: ______________________

☐ Yes ☐ No Do you have an advance directive? (If so, please provide a copy for your medical records.)
(*Living Will, Health Care Power of Attorney, Advanced Instruction for Mental Health Treatment, Organ Donor Card)*

☐ Yes ☐ No Would you like information on advance directives?

☐ Yes ☐ No Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If so, by whom? ______________________

☐ Yes ☐ No Do you feel safe in your current relationship/environment?

☐ Yes ☐ No Is there a partner from a previous relationship who is making you feel unsafe now?

Patient Signature: ______________________ Date: ____________ Time: ________

<u>To be reviewed by provider once a year or when changes occur</u>

Reviewed by:	Initials / Date		Initials / Date
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NOVANT HEALTH

Patient Personal Data

74016 R 03/18/2013

Name / MR # / Label