ROUND ROCK - AUSTIN - TULSA - McCALESTER - MEEKER - WAGONER

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	Who is your old Primary Care Physician?		Have you been a patient of ONI before? ☐Yes ☐No	
PATIENT ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	Last	First	MI	Date of Birth Age
	Address		City	State ZIP
	Sex: ☐Male ☐Female		Are you a Student? ☐Yes ☐No	
	Street Address (If different from mailing)		City	State ZIP
	Phone (Home)	Name of Employer		Employer's Phone #
	Phone (Mobile)	Employer's Address		
	Preferred Method of Contact? ☐Home Phone ☐Mobile Phone May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐No			
	Email:			
	Spouse's Name		Date of Birth	
ADDITIONAL INFORMATION	Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer			
	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	What Language do you Prefer? ☐ English ☐ Spanish		
	Name of your Pharmacy	Address		
	City State ZIP			Phone #
RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Guardian ☐ Other	Last First MI		Phone Number:	
	Address			
	City		State	ZIP
IN CASE OF EMERGENCY NOTIFY	Name		Relation	
	Address		Phone #	
INSURANCE INFORMATION	Primary Insurance		Address	
	Policy Contract #	Group#	City State	ZIP
	Name of Policy Holder		Date of Birth	
	Secondary Insurance		Address	
	Policy Contract #	Group#	City State	ZIP
	Name of Policy Holder		Date of Birth	

ALLERGIES TO MEDICATIONS OR ENVIRONMENTAL

Medication or Other (Environmental)	Reaction

FAMILY HISTORY
(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Siblings
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brother, or sisters are deceased, please list the age at the time of their death and the cause:

Relationship	Cause of Death	Age at Death	Relationship	Cause of Death	Age at Death

YOUR HEALTH HISTORY
(Check if you have had any of the following)

☐	Abnormal Heart Rhythm	☐	Chronic Pain	☐	Heartburn/GERD	☐	Obesity
☐	Allergies (Any)	☐	Chronic Kidney Disease	☐	Heart Murmur	☐	Osteoporosis
☐	Anemia	☐	Depression	☐	Hepatitis	☐	Peripheral Vascular Disease
☐	Anxiety/Stress	☐	Diabetes	☐	High Blood Pressure	☐	Seizures/Epilepsy
☐	Asthma	☐	Emphysema/COPD	☐	High Cholesterol	☐	Sleep Apnea
☐	Arthritis	☐	Gallbladder Disease	☐	HIV/AIDS	☐	Stomach Ulcers
☐	Atrial Fibrillation	☐	Gout	☐	Irritable Bowel Syndrome	☐	Stroke
☐	Colitis or Crohn's Disease	☐	Headache/Migraines	☐	Kidney Failure	☐	Thyroid Disease
☐	Cancer	☐	Heart Attack/Failure	☐	Kidney Stones		

Please list any additional health conditions:_____

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician
Colonoscopy			
Cholesterol Screening			
Cardiac Stress Test			
Bone Density			
Mammogram			
Breast Exam			

Vaccine Type	Date
Tetanus (Td)	
Pneumonia	
Hepatitis B	
Influenza (Flu)	
Shingles	
Other	

OB/GYN HISTORY

Date of Last Menstrual period:	
Are you currently on a birth control:	
Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/mis-carriages	
Number of Living Children	
Date started menopause	

ACCIDENTS - TRAUMA

Is your visit related to an accident? ☐YES ☐NO If so, date of accident/injury:_____
Type of accident: ☐Job* ☐Automobile ☐Other Brief description of accident:

Are you respresented by an attorney? ☐YES ☐NO Name:_____ **Phone:**_____
Do you have any metal pins/plates in your body? ☐YES ☐ NO If yes, please describe:

If your visit is due to a Worker's Compensation Claim, you must have a referral and your visit must be pre-approved
**Failure to provide this information will result in your appointment being rescheduled.*

PAST SURGICAL HISTORY

DATE	SURGERY	DATE	SURGERY

Please list any additional Medical Information

REFERRING INFORMATION

How did you hear about our practice? ☐Internet ☐Yellowpages ☐Prior Patient ☐Friend/Family member ☐Your Physician ☐Insurance Carrier ☐Other_____

Referring Doctor_____ **Address**_____ **Phone** _____

Family Doctor_____ **Address**_____ **Phone** _____

Do you now/have you ever smoked? ☐YES ☐NO If yes, how long have/did you smoke? _____

How many packs per day? _____

Did you quit? ☐YES ☐NO If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____

How many days per week do you exercise? _____

In the past six months have you had a regular problem with pain? ☐YES ☐NO Where? _____

Do you wear glasses/corrective lenses? ☐YES ☐NO

Do you wear a hearing aid? ☐YES ☐NO

Do you use any of the following equipment?

Device	Yes/No
Cane	
Electronic Scooter	

Device	Yes/No
Walker	
Wheelchair	

Device	Yes/No
Bi-pap (sleep apnea)	
C-pap (sleep apnea)	

Do you follow a healthy diet? ☐YES ☐NO Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

LIST ALL PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

Name	Dose	Frequency	Ordering Provider

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

Specialty	Physician	Specialty	Physician	Specialty	Physician
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? ☐YES ☐NO If yes, please supply the office with a copy for your chart. If no, would you like one? ☐YES ☐NO

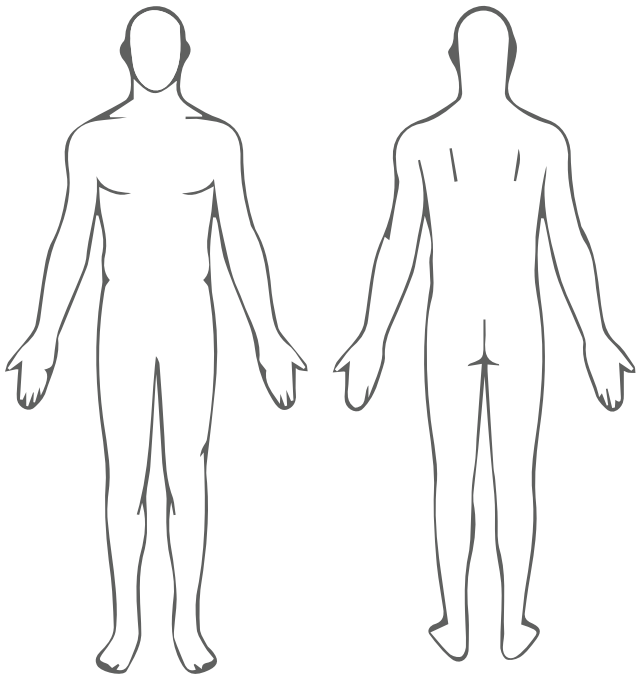
PAIN DIAGRAM AND PAIN RATING

(if applicable)

Instructions: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.
*(for example: if you are experiencing pins and needles on your right ankle, you would draw an '**0**' near the right foot on the diagram below.)*

KEY:

Pins and Needles	=	0 0 0 0 0 0 0	Stabbing	=	/ / / / / / / / /
Burning	=	X X X X X X	Deep Ache	=	Z Z Z Z Z Z



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please describe in your own words how your injury occured: