Lori Hansen, M.D.
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Oklahoma City, OK 73120
405-753-9600

Patient Medical Information

PLEASE PRINT: Date:_____

Name: _____ Email:_____@_____
(PLEASE PRINT)

Address:_____
Street **City** **State** **Zip**

Date of Birth: _____ Age: ____ Sex: ____ SSN: _____--_____--_____

Telephone (Home)_____ Cell: _____ Work:_____ Ext:_____

Occupation:_____ Employer:_____

Primary Physician: _____ Phone: _____ Last Seen:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

How did you hear about our office? (Please circle all that apply)

- Friend (please list name so he/she can receive credit)_____
- The Oklahoman The Local Paper _____ The Gazette Yellow Pages
- Radio Television Other (please explain):_____

Are you using (or used in the past): □ Azelex □ Differin □ Renova □ Retin A □ Tretinoin □ Tazorac □ Glycolic □ Alphahydroxy □ Accutane

If so, when and for how long? _____ Prescribing Doctor: _____

Do you wear sunscreen and how often: _____ What Brand? _____

Name of Pharmacy: _____

Address: _____ Phone#:_____

Social Information

Exercise	Caffeinated Beverages	Smoking	Alcohol
Y N Kick Boxing Y N Running Y N Walking Y N Biking Y N Dancing Other: _____	_____Coffee (cups/day) _____Tea (glasses/day) _____ Soda (cans/day)	____ Never ____ Quit ____ Cigarettes ____ # packs/day ____ Cigar ____ Chew	____ Never ____ Beers/wk (cans) ____ Wine/wk (glasses) ____ Liquor/wk (shots) ____ Past History Abuse ____ DWI

.

List Current Medications / Vitamins / Supplements	**mg**	**# pills AM**	**Noon**	**PM**	**Bedtime**		**List All Food, Drug, Seasonal, or Cosmetic Allergies**	**What reaction did you have?**

Patient Name**: _____** **DOB: _____**

Past Medical History: Check below any problems you have now or you have had in the past.

Please List Any Other Past Medical Problems or Injury	**Year**
PAST SURGERIES:	

ASTHMA	__Y __N	CIRRHOSIS	__Y __N	DIABETES	__Y __N
PNEUMONIA	__Y __N	HEPATITIS	__Y __N	KIDNEY STONE	__Y __N
TUBERCULOSIS	__Y __N	STROKE	__Y __N	ULCERS	__Y __N
HEART TROUBLE	__Y __N	SEIZURES	__Y __N	COLD SORES	__ Y__N
RHEUMATIC FEVER	__Y __N	MIGRAINES	__Y __N	FEVER BLISTERS	__ Y__N

System Review – Check Yes or NO (if you now have or have had recently)

GENERAL			**GI**	
Skin Rash	___Yes ___No		Heart Burn	___Yes ___No
Lethargy	___Yes ___No		Difficulty Swallowing	___Yes ___No
Weight gain/loss	___Yes ___No		Stomach Ulcers	___Yes ___No
Tend to be cold or hot	___Yes ___No		Vomiting Blood	___Yes ___No
Night Sweats	___Yes ___No		Constipation	___Yes ___No
Thyroid Problems	___Yes ___No		Diarrhea	___Yes ___No
Bleeding Problems	___Yes ___No		Black or Tarry Stools	___Yes ___No
Recent Change in Bruising	___Yes ___No		Hemorrhoids	___Yes ___No
Cancer	___Yes ___No		Other	_____
HIV	___Yes ___No			

EYE/EAR			**HEART**	
Wear Glasses/Contacts	___Yes ___No		Heart Racing/Palpitations	___Yes ___No
See Double	___Yes ___No		High Blood Pressure	___Yes ___No
Eye Pain	___Yes ___No		Swollen Feet or Ankles	___Yes ___No
Deafness	___Yes ___No		Chest Pain with Exertion	___Yes ___No
Ringing in Ears	___Yes ___No		Heart Attack	___Yes ___No
Dizziness	___Yes ___No		Heart Murmur	___Yes ___No
Other	_____		Other	_____

LUNG			**GU**	
Wheezing	___Yes ___No		Blood in Urine	___Yes ___No
Persistent Cough	___Yes ___No		Leaking Urine	___Yes ___No
Shortness of Breath	___Yes ___No		Burning on Urination	___Yes ___No
COPD/Emphysema	___Yes ___No		Frequent Daytime Voiding	___Yes ___No
Cough Up Blood	___Yes ___No		Frequent Nighttime Voiding	___Yes ___No
Exposed to TB	___Yes ___No		Kidney Disease	___Yes ___No
Other	_____		Sex Difficulties	___Yes ___No
			Other	_____

Patient Name: _____ DOB: _____

NEURO			MISC.	
Recent Change in Headache Frequency	___Yes ___No		Aching Muscles	___Yes ___No
Daytime Sleepiness	___Yes ___No		Aching Joints	___Yes ___No
Trouble Sleeping	___Yes ___No		Leg Cramps	___Yes ___No
Seizures	___Yes ___No		Other	_____
Head Injury	___Yes ___No			
Memory Loss/Problems	___Yes ___No			
Cry Often/Sad	___Yes ___No			
Depressed	___Yes ___No			
Worry a Lot	___Yes ___No			
Other	_____			

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Lori Hansen, M.D.

I acknowledge that I have received a copy of the Patient Privacy Notice.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe the relationship to the patient:

_____

_____