

**HAND & UPPER EXTREMITY CENTER, PA**  
**OLAYINKA OGUNRO, M.D., F.A.C.S**  
**CHARITY OGUNRO, M.D.**

**PATIENT INFORMATION SHEET**  
**THIS FORM MUST BE FILLED OUT WITH ALL APPLICABLE INFORMATION**  
**NOTE: PATIENT IS RESPONSIBLE FOR ALL BILLS**

**PLEASE PRINT**

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

Patient's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Widow: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Hm. Phone: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Pharmacy Name & No: \_\_\_\_\_

Cell #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Race: White, Hispanic, Asian, African-American, Other \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Patient's Responsible Party's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Position: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Employer: \_\_\_\_\_

If child, parent's name: \_\_\_\_\_ SS #: \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Insured's D.O.B.: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_ Cert. or Policy #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_ Referred By: \_\_\_\_\_

On the job injury: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Chief Complaint (Reason for visit): \_\_\_\_\_

Present illness, include dates and previous treatment: \_\_\_\_\_

Family History: \_\_\_\_\_

Past Medical History (diabetes, hypertension, HIV, heart problems, gastric ulcers, etc.): \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Review of systems: (Please circle all that apply)

General: chills, fever, fatigue, night sweats and weight loss

HEENT: hearing problems, ear/nose/throat pain, congestion, runny nose, nose bleeds, hoarseness and dental problems

Cardiovascular: chest pain, palpitations, increased heart rate, orthopnea, and edema.

Respiratory: cough, dyspnea, and coughing up blood

Gastrointestinal: abdominal pain, heartburn, constipation, diarrhea and stool changes

Urinary: urgency, frequent urination, painful urination, blood in the urine, waking up at night to urinate, incontinence, stones, infection

Vascular: leg edema, leg cramping, varicose veins, thromboses/emboli

Musculoskeletal: muscle weakness, pain, joint stiffness, instability, redness, swelling, gout, except for areas of symptoms.

Neurologic: loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, seizures

Endocrine: heat/cold intolerance, excessive sweating, polyuria, polyphagia, excessive thirst

Personal History:

Use of drugs: Yes: \_\_\_\_\_ No: \_\_\_\_\_ How much: \_\_\_\_\_

Do you smoke: Yes: \_\_\_\_\_ No: \_\_\_\_\_ How much: \_\_\_\_\_

Do you drink alcohol: Yes: \_\_\_\_\_ No: \_\_\_\_\_ How much: \_\_\_\_\_

Current Medications You Are Taking: \_\_\_\_\_

Are you taking: Diet Pills, Vitamins or Herbs: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Are you Right Handed: \_\_\_\_\_ or Left Handed: \_\_\_\_\_

Type of work you do? \_\_\_\_\_

Describe in detail your job duties: Example...Pushing, Pulling, Keying, Bending, Lifting (How many lbs?) and Typing.

**I hereby authorize my insurance benefits to be paid to the physician and I do realize I am financially responsible for non-covered services. I also authorize the physician to release any medical information and records required in the processing of claims.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date