Oklahoma State University Medical Center

Harvard Family Medicine

Dr. Stephen Barnes, Dr. Joe Wolf & Galina Michka, MS, APRN-C
(918) 748-8111

Welcome to Oklahoma State Medical Center/Harvard Family Medicine. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits and accept walk-ins for first available slots for all sick visits. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. You will be asked to fill out new registration forms annually so we may update your information as it is a requirement.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made. If you are a self pay patient and do NOT have insurance we will offer you a 40% discount if you pay in full the same day as your visit. If you are unable to pay the full amount payment arrangements can be made but we will not be able to offer the discount.

We ask that you allow plenty of time to get to the office for your appointment. Your appointment will be cancelled if you are greater than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications (vitamins, natural remedies, etc) with you at each visit.

Our office policy for a missed appointment is:

- You must give a 24 hour notice of cancellation for your appointment. If you have (3) or more missed appointments you will receive a warning letter to remind you that keeping your appointments are necessary to give you the best care possible. In order to achieve the best outcome for your medical care it is pertinent that you maintain your regularly scheduled follow up appointments.
- If you have three (3) no-show appointments it will result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment. (918) 748-8111

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. ***Harvard Family Medicine does not offer chronic pain management and will not dispense chronic pain medication*** (for example, chronic daily narcotics like Norco or Percocet). We will

provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.

2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30,60 or 90 days at a time upon our physicians discretion during your office visit.
    a. We ask that you allow enough time for us to make an appointment for management of your chronic disease so you're not without your medication.
3. For the safety and well-being of our patients,
    a. Requests for ***new*** medications (including antibiotics) and medication refills will not be taken over the phone or over the internet during office hours without an appointment and evaluation by the physician.
    b. No new medications (including antibiotics) will be called in over the phone ***after*** office hours by the on-call physician.
    c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the on-call physician. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills.

If you need to reach the physician after hours, you can reach our answering service at (918) 748-8111. Our office hours for patient care are Monday & Tuesday 8am-4:30pm, Wednesday 8am-3:30pm, and Thursday & Friday 8am-4:30pm. If you have a concern that you feel management needs to be made aware of please notify our nursing manager, Angela Kihega, RN at (918) 209-5170.

Our physicians are affiliated with Oklahoma State University Medical Center. They will be directing their patients to use OSUMC's services. Our electronic medical record allows us to receive patient results quickly and efficiently through our direct link with OSUMC services. This is an important resource in meeting our goal of providing high quality care in a timely manner.

Welcome to our practice and thank you for choosing Harvard Family Medicine and OSUMC for all your health care needs.

Sincerely,

Stephen Barnes, D.O
Joe Wolf, D.O
Galina Michka, MS, APRN-C

NEW PATIENT MEDICAL HISTORY FORM

Oklahoma State University Medical Center
Harvard Family Practice- Dr. Barnes/Dr. Wolf/Galina Michka, APRN-C
3345 S Harvard, Suite 210
Tulsa, OK 74135
918-748-8111

Date___/___/_____

Name: _____ Date **of Birth**: ____/____/____
Marital Status: Married / Single / Divorced / Widowed **(please circle)**
PLEASE COMPLETE ALL PAGES- IF YOU ARE UNSURE OF EXACT DATES ESTIMATES WILL BE FINE.
Reason for your visit today:
_____

_____

MEDICATIONS: Please list ALL medications- prescription and over the counter medications (example: natural remedies, vitamins, tylenol, etc.)

Medication *Ex: Tylenol*	**Dosage** *Ex: 500mg*	**Frequency** *Ex: 1 3x day*	**Started month/yr** *Ex 12/2013*	**Prescribed by:** *Ex: Dr Smith*

Medication or Food Allergy (ex: cipro)	**Type of reaction (ex: rash)**

Check Mark each immunization that you have had:

___ **Hepatitis A** Date: ___/___/___ ___ **Varicella (chicken pox)** Date: ___/___/___

___ **Hepatitis B** Date: 1.) ___/___/___, 2.) ___/___/___ , 3.) ___/___/___

___ **Tetanus Shot** Date: ___/___/___ (**Was pertussis included –TDAP)?** Yes / No (circle one)

___ **Influenza (flu)** Date: ___/___/___ ___ **Rubella** Date: ___/___/___

___ **Pneumonia** Date: ___/___/___ ___ **Zostavax** (Shingles Vaccine) Date: ___/___/___

___ **Measles** Date: ___/___/___ ___ **Flu Vaccine** Date: ___/___/___

___ **HPV (3 shots)** Date 1.) ___/___/___, 2.) ___/___/___/, 3.) ___/___/___.

Please write the approximate dates of the most recent tests you have completed

___/___/___ **Bone Density Screening (osteoporosis)**

___/___/___ **Cardiac Stress Test**

___/___/___ **Pap Smear**

___/___/___ **Cholesterol/Lipid labs**

___/___/___ **Chest X-Ray**

___/___/___ **Colonoscopy/EGD**

___/___/___ **EKG**

___/___/___ **Diabetic A1C Lab Test**

___/___/___ **Prostate exam**

___/___/___ **Ultrasound (if yes what Kind?)** _____

___/___/___ **MRI (If yes what body area- brain, back, legs, arms, other-please circle)**

___/___/___ **Mammogram/Breast- if abnormal please give details:**

Other testing you may have had done that is not listed here:

_____

_____

SURGICAL HISTORY:

Surgery Type:	Physician/Surgeon	Date : month/year	Location/Hospital

FAMILY HISTORY

Relation	Heart Disease	Diabetes	Lung Disease	Cancer/ Type	Stroke	High Cholesterol	High Blood Pressure	Mental Illness	Age(now or at death
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Siblings Brother/Sister									
Siblings Brother/Sister									
Siblings Brother/Sister									
Siblings Brother/Sister									

Please List any other pertinent family history here:

_____

_____

_____

_____

SOCIAL HISTORY:

1. Do you smoke?
( ) No, I have never smoked.
( ) Yes, I smoke ___ packs of cigarettes a day for ___ yrs.
( ) No, I quit smoking ___ yrs. ago. I smoked ___ packs a day for ___ yrs.
( ) Yes, I smoke cigars or a pipe, ___ a day for ___ yrs.
( ) Yes, I use snuff ____ times a day or ____ times a week or only on Occasion _____.

2. Do you drink alcoholic beverages?
( ) Beer ____ cans per day / week / month / year (circle one)
( ) Wine____ glasses per day/ week / month / year (circle one)
( ) Other: _____How Much ?_____.

3. How much caffeine do you drink on a daily basis: (coffee, tea, colas)? _____.

4. Have you ever used illicit drugs (marijuana, meth, heroin, cocaine, LSD, etc)? Yes / No
Currently using / Used in the past (circle one) Last used _____
Have you ever used illicit drugs intravenously? Yes / No
If yes please list illicit drugs that are/ or were used:

_____

_____.

Are you sexually active? Yes / No **Are your partners** male / female / or both? **(Please circle)**
Do you use contraception? None Condoms Pill Vasectomy IUD Diaphragm Tubal Ligation (**please circle)**
Do you practice safe sex? Never / Sometimes / Always **(please circle)**
For Woman Only:
Number of pregnancies: _____
Number of live births: _____
Number of abortions/miscarriages: _____
Date of your last period? ___/____/____

What is your occupation:
_____.

Please check if the following pertain to safety behaviors you follow:

( ) Wear Seatbelt	**( ) Wear helmet while riding bike or motorcycle**
( ) Smoke detector in home	**( ) Fire extinguisher in home**
( ) Guns in the home	**( ) Guns are kept locked up at all times**

Do you have advanced directives?
(Living Will, Durable Power of Attorney for medical decisions) Yes / No **(please circle one)**
If No, would you like information regarding advanced directives? Yes No

Do you have a signed DNR (Do Not Resuscitate)? Yes No **(please circle one)**

Please list any other physicians or health care providers you see (specialist, therapists, counselors, chiropractors, eye doctors, etc)

Provider: _____ Reason: _____

Provider: _____ Reason:_____

Provider: _____ Reason:_____

Provider: _____ Reason:_____

Hospitalizations:

Month/Year	Hospital Name/ Location (city , state)	Reason for hospitalization

Review of Symptoms/Health History: Please check any current problems you are having listed below:

General
__ Fevers/Chills/Sweats
__ Unexplained weight loss/gain
__ Unusual fatigue
__ Excessive thirst or urination
__ Hot flashes

Musculo-Skeletal
__ Muscle/ Joint Pain
__ Back Pain

Cardiovascular
__ Chest pain/discomfort
__ Irregular heart beat
__ swelling of feet or hands
__ High blood pressure
__ Heart Murmur
__ Pacemaker in place- Year_____
__ Defibrillator – Year _____
__ History of blood clots
__ History of heart attack Stents? _____

Please check any of the problems you are experiencing: (continued)

Ears/Nose/Throat/
__ Sore throat/ hoarseness
__ Nasal Congestion
__ Hay fever/ allergies
__ Hearing loss right/ left/ both
__ Ringing in ears
__ Nose bleeds
__ Ear Pain Left / Right

Respiratory
__ Cough productive/ Non-productive
__ Shortness of breath
__ Asthma
__ Wheezing

Genitourinary
__ Frequent urination
__ Painful urination
__ Slow urine stream
__ Bladder leakage (incontinent)
__ Unusual vaginal bleeding or discharge
__ Penile discharge
__ Painful sexual intercourse

Psychiatric
__ Anxiety/stress
__ Problems with sleep (insomnia)
__ Depression
__ Mood swings
__ Irritability
__ Claustrophobic

Blood/Lymphatic
__ Bruises easily
__ Bleeds excessively
__ Cancers? _____

Skin
__ Changes in moles
__ Rashes
__ Itching

Breast (Woman Only)
__ Breast Lump left / right/ both (circle)
__ Nipple Discharge left /right /both

Gastrointestinal
__ Constipation
__ Diarrhea
__ Abdominal Pain
__ Nausea/ or vomiting
__ Gallbladder issues
__ Heartburn
__ Coughing up blood
__Blood in stools
__ Hemorrhoids

Men Only
__ Prostate problems
__ Impotence
__ Last prostate exam ___/___/____

Neurological
__ Headaches
__ Dizziness/ light headedness
__ Leg pain/numbness
__ General weakness
__ Memory Loss
__ Loss of balance
__Seizures
__ History of stroke, if so ___/___/____
__ Have you had a recent fall? __/__/__

Eyes
__ Change in vision
__ Blurred vision
__ Cataracts
__ Glaucoma
__ Last eye exam ___/___/____

Mouth
__ Dentures? If so what age? _____
__ Jaw pain/ popping
__ Dental problems
__ Frequent mouth sores