Thank you for taking the first step in preparing to create your electronic medical record. After you have printed out the Patient Information Form please complete the form and fax the finished pages to:

(440) 460-2885

Or mail the form to:

Fred S. Hirsh, M.D., Inc.
6551 Wilson Mills Rd.
Mayfield Village, Ohio 44143
Attention: Patient Forms

Alternatively, you may bring the forms with you to your appointment but this may require a few extra minutes during your visit with us.

Thank you,

Dr. Alex and Fred Hirsh and Staff
Patient Information Form

Patient Name: ____________________________________________ □ Male □ Female

(Please Print)                          First                             Middle                             Last

Date of birth: __________________________  Age: ______  Patient Social Security Number _________________________________

Home Address: ____________________________________________

Street                             Apartment number

__________________________________________

City                             State                             Zip code

Seasonal Address: __________________________

(From: __________ to __________) Street                             Apartment number

_______________________________________

City                             State                             Zip code

Home Phone:  (______)____________________  □ Single       □ Married       □ Divorced       □ Widow

Business Phone: (______)____________________

Mobile Phone: (______)____________________  Email: _________________________________

Preferred Phone: □ Home □ Work □ Mobile

Is it OK to contact you via email? □ Yes □ No

Is it OK to leave a detailed message? □ Yes □ No

Insurance Policy Holder’s information: (billing information should be sent to: □ patient address   □ insurance policy holder address)

Name: ____________________________________________

First                             Middle                             Last

Date of birth: __________________________  ID Number/Social Security Number _________________________________

Address: __________________________

□ Same as above Street                             Apartment number

__________________________________________

City                             State                             Zip code

Pharmacy Information

Pharmacy Name: ____________________________________________

Pharmacy Address (or intersection): ____________________________________________

Pharmacy Zip Code: ____________________________________________

Pharmacy Phone: (______)__________________________

Mail Away Pharmacy Name: ____________________________________________

Patient Name: __________________________

Date: __________________________
Medical History:
Select any of the following conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- BPH
- Bone Marrow Transplant
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Other

Have you had any of the following skin conditions:

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Cancer
- Blisters Solar Burns
- Dry Skin
- Eczema
- Other

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Mastectomy
- Bladder (Left)
- Breast: Left Breast
- Breast: Both Breasts
- Breast: Lumpectomy
- Breast: Right Breast
- Breast: Left Breast
- Breast: Both Breasts
- Breast: Breast Biopsy
- Breast: Breast Reduction
- Breast: Breast Implants
- Colon
- Colon Cancer Resection
- Diverticulitis
- Inflammatory Bowel disease resection
- Gallbladder: Cholecystectomy
- Heart: Coronary Artery Bypass Surgery
- Heart: PTCA
- Heart: Mechanical Valve
- Heart: Biological Valve
- Heart: Heart Transplant
- Heart: Joint Replacement
- Knee (Both)
- Knee (Right)
- Knee (Left)
- Hip (Both)
- Hip (Right)
- Hip (Left)
- Kidney Transplant
- Kidney Biopsy
- Kidney Nephrectomy
- Kidney Stone Removal
- Ovary removal:
- Endometriosis
- Ovarian Cyst
- Ovarian Cancer
- Prostate:
- Prostate Cancer
- Prostate Biopsy
- TURP
- Skin biopsy: Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Heart
- Melanoma
- Splenectomy
- Testicles (orchidectomy)
- PTCA
- Hysterectomy (fibroids)
- Hysterectomy: Uterine Cancer
- Other

Do you have any allergies to medications?
- No
- Yes (Please list and include the allergic reaction that occurs when taking that medication):

1. 
2. 
3. 
4. 
5. 

Do you smoke? □ No □ In the past (year quit _________)
□ Yes (□ occasionally □ daily (packs per day_________)

Patient Name: ___________________________
Date: _________________________________