Internal Medicine Associates, LLC

Health and History

Date: Patient Name: DOB: Gender: ___Age: ___

Occupation: _____ Marital Status: _____

Referring M.D.: _____ Primary Care Provider: _____

Chief Complaint/Reason for Visit: _____

Medications/Vitamins (Prescription and/or over the counter)

Name:	Size (mg):	Times/day:	Prescribed by:

Allergy/Reaction

Drug name	Reaction

Surgery	**Year**

Hospitalization	**Year**

Social History

Do you currently use tobacco? ___ Yes ___ No Have you ever used tobacco? ___ Yes ___ No

per day: ___ Cigarettes ___ Cigars ___ Chewing What years have you used tobacco products? _____

Do you drink alcohol? ___ Yes ___ No # per week of: ___ Beer ___ Wine ___ Liquor

Do you drink caffeine? ___ Yes ___ No # per day of: ___ Coffee ___ Tea ___ Cola

Recreational or I.V. Drug use? Yes No What kind/number of pets?

Family History

__ Heart disease – Relative: _____
__ Hypertension – Relative: _____
__ Emphysema – Relative: _____
__ Colon polyps – Relative: _____
__ Gallbladder disease – Relative: _____
__ Diabetes – Relative: _____
__ Sleep apnea – Relative: _____

___ Cancer – Relative: _____
___ Asthma – Relative: _____
___ Colitis – Relative: _____
___ Colon cancer – Relative: _____
___ Hepatitis – Relative: _____
___ Depression – Relative: _____
___ Other – Relative: _____

Relative:	Age:	Illness:	Deceased:	
Father	_____	_____	___ Yes	___ No
Mother	_____	_____	___ Yes	___ No
Brother	_____	_____	___ Yes	___ No
Sister	_____	_____	___ Yes	___ No
Child	_____	_____	___ Yes	___ No
Grandmother	_____	_____	___ Yes	___ No
Grandfather	_____	_____	___ Yes	___ No

TURN OVER AND COMPLETE OTHER SIDE

Patient Name: DOB

Past Medical History & Review of Systems – check all that apply

Systemic

Review of Systems:

___ Fatigue
___ Fever
___ Chills
___ Change in weight
___ Night sweats

EENT

Past Medical History:

___ Glaucoma
___ Hearing loss

Review of Systems:

___ Headache
___ Sinus pressure
___ Neck pain/stiffness
___ Neck swelling/lump
___ Vision problems
___ Eye itching/pain
___ Ear ache
___ Nasal discharge/blockage
___ Hoarseness
___ Sore throat
___ Bleeding gums
___ Mouth sores

Cardiovascular

Past Medical History:

___ High blood pressure
___ High cholesterol
___ Heart attack
___ Heart murmur
___ Prolapsing Mitral Valve
___ CAD
___ On blood thinners
___ Blood clots
___ Angina

Review of Systems:

___ Chest pain
___ Palpitations

Pulmonary

Past Medical History:

___ Asthma
___ Bronchitis
___ History of TB
___ Use of BCG vaccine
___ Emphysema
___ COPD
___ Apnea
___ Abnormal chest X-ray/chest CT
Date/Location:_____

Pulmonary - continued

Review of Systems:

___ Cough
___ Wheezing
___ Shortness of breath
___ Snoring
___ Excessive daytime sleepiness
___ Chest pain w/ deep breathing
___ Chest pain w/ rotating torso

Gastrointestinal

Past Medical History:

___ Crohn's Disease
___ Ulcerative Colitis
___ Esophageal Reflux
___ Hepatitis
___ Gallbladder Disease/Gallstones
___ Colon cancer
___ Intestinal Polyps removed
Date: _____

Review of Systems:

___ Appetite changes
___ Difficulty swallowing
___ Heartburn
___ Nausea
___ Vomiting
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Change in bowel habits
___ Bloody or black stools
___ Uncontrollable gas/bloating

Genitourinary

Past Medical History:

___ Urinary tract infection (UTI)
___ Kidney stones
___ Are you pregnant?
Date of last period: _____

Review of Systems:

___ Blood in urine
___ Burning during urination
___ Increased urinary frequency

Musculoskeletal/Rheumatology

Review of Systems:

___ Joint pain/stiffness
___ Joint swelling
___ Back pain
___ Muscle aches or weakness
___ Scleroderma
___ Other: _____

Neurological

Review of Systems:

___ Dizziness
___ Fainting
___ Numbness
___ Sensory disturbances
___ Stroke
___ Seizure disorder

Endocrine

Past Medical History:

___ Thyroid disease
___ Thyroid cancer
___ Adrenal tumor
___ Pituitary tumor
___ Parathyroid disease
___ Osteoporosis
___ Diabetes
___ Gestational diabetes

Review of Systems:

___ Heat or cold intolerance
___ Excessive thirst or urination
___ Excessive sweating
___ Change in libido (sex drive)
___ Change in shoe or ring size
___ Stretch marks
___ Facial hair growth (women)

Psychological

Past Medical History:

___ Anxiety
___ Depression

Review of Systems:

___ Sleep disturbances
___ Confusion
___ Memory lapse or loss
___ Other: _____

Skin

Past Medical History:

___ Eczema
___ Psoriasis

Review of Systems:

___ Itching
___ Skin lesions
___ Rashes

Hematologic

Past Medical History:

___ Anemia
___ Easy bleeding

Other

___ HIV-1 infection

Patient Signature: _____ Physician Signature: _____ Date: _____

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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION
(REQUEST FOR RELEASE OF MEDICAL RECORDS)

I, _____ date of birth _____, authorize Internal Medicine Associates, LLC. to use and/or disclose my health information to: **Myself** and/or _____.

I authorize disclosure of the following types of health information

Types of Health Information *If not checked, default is ALL TYPES*	**Date(s) of Service for requested records** *If left blank, default is ALL DATES*	**For the following purpose(s)** *If not checked, default is CONTINUATION OF CARE*
☐ Office/ Provider Notes	_____	
☐ Laboratory Reports	_____	☐ Continuation of Care
☐ Pathology and Biopsy Reports	_____	☐ Personal Request
☐ Imaging Studies	_____	☐ Insurance Claims
☐ Billing Statements	_____	☐ Legal Request
☐ Other: _____	_____	☐ Other:_____

* The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV/HCV/AIDS / SEXUALLY TRANSMITTED related health information and/or records

_____ *Mental health information and/or records

_____ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information): _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **the Practice Manager or the Privacy Officer**. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand I have a right to obtain a copy of this Authorization, upon requesting. **I understand that this form does not supersede any previously signed Release of Information.**

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

_____ _____
Signature of Individual or Individual's Legal Representative | Date Signed (Expires one year after signature)

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Individual

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