

NAME: _____ DATE OF BIRTH: _____

ALLERGIES: MEDICATIONS AND TYPE OF REACTION: Use other side if needed.

CURRENT MEDICATIONS AND DOSES. PLEASE INCLUDE SUPPLEMENTS ALSO.
(PRESCRIBED AND OVER-THE-COUNTER) Use other side if needed.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

PAST MEDICAL HISTORY: List chronic medical conditions, illnesses, and hospitalizations. (please included approximate dates if known)

IMMUNIZATIONS: Date of last flu shot: _____

Date of last pneumonia shot: _____

SURGERIES: List any and all surgeries you have had. (please included approximate dates if known)

FAMILY HISTORY: (circle living or deceased)

Father living or deceased. Died at age _____ Health problems: _____

Mother living or deceased. Died at age _____ Health problems: _____

Brothers or sisters and their health _____

Other conditions that run in your family: _____

SOCIAL HISTORY:

Marital Status: (circle one) Married Single Divorced Separated Widowed Other

Number of children and their ages: _____

Your Occupation: _____

Spouse or significant other's occupation: _____

Smoking History: (circle one) Current smoker Previous smoker Never smoked

If current smoker or previous smoker, in what year did you start smoking? _____

What do you or did you smoke? Cigarettes Cigars Pipe

Amount smoked per day _____

If you quit smoking, in what year did you quit smoking? _____

Alcohol use: Do you drink alcoholic beverages? Yes No

If so, how many drinks do you have in a typical week? _____

What do you typically drink? _____

Do you use illegal drugs? Yes No If so, what type _____

Mark any of the following with an that represent significant and on-going problems for you

General:

- fevers
- chills
- sweats
- poor appetite
- weight loss

Eyes:

- blurred vision
- double vision
- irritation
- discharge from the eyes
- vision loss
- eye pain
- extreme sensitivity to light

Ears/Nose/Throat:

- earache
- ear discharge
- ringing in the ears
- decreased hearing
- nasal congestion
- nosebleeds
- sore throat
- hoarseness
- trouble swallowing

Cardiovascular:

- chest pains
- skipping or racing heart beats
- fainting or passing out
- shortness of breath with activity
- shortness of breath when lying flat
- edema (swelling)

Respiratory:

- cough
- shortness of breath
- excessive sputum (phlegm)
- coughing up blood
- wheezing

Gastrointestinal:

- nausea
- vomiting
- diarrhea
- constipation
- change in bowel habits
- abdominal pain
- black tarry bowel movements
- blood in bowel movements
- yellow skin or eyes (jaundice)

Female Reproductive:

- irregular menses
- hot flashes
- decreased sex drive
- age periods started _____
- last normal menses _____
- number of pregnancies _____
- age of menopause _____

Genitourinary:

- burning with urination
- blood in urine
- discharge
- urinary frequency
- urinary hesitancy
- waking up at night to urinate
- incontinence (leaking urine)
- genital sores

Musculoskeletal:

- back pain
- joint pain
- joint swelling
- muscle cramps
- muscle weakness
- stiffness
- arthritis

Skin:

- rash
- itching
- dryness
- suspicious lesions

Neurologic:

- paralysis
- weakness
- numbness
- seizures
- fainting (syncope)
- tremors or shakes
- dizziness
- headache

Psychiatric:

- depression
- anxiety
- memory loss
- mental disturbance
- suicidal thoughts
- hallucinations

Endocrine:

- cold intolerance
- heat intolerance
- excessive thirst
- excessive hunger
- excessive urination
- weight change

Male Reproductive:

- change in shaving frequency
- breast enlargement or tenderness
- erectile dysfunction
- decreased sex drive

Heme/Lymphatic:

- abnormal bruising
- bleeding
- enlarged lymph nodes



Community Physicians of Indiana

Diabetes, Internal Medicine, Endocrinology

What you need to know . . .

In order to help all of our patients in a timely manner, please review the following material...

For prescription refills... Please request your prescription refills at the time of your office appointment. If you need to request a refill by phone, **PLAN AHEAD**, two business days may be needed to complete this process. If you require a *90 day* prescription, we are happy to provide this for you. However, you will be responsible for mailing to your insurance company with the appropriate paperwork.

For lab orders... Please request your lab order form at the time of your office appointment. If you lose your order and need to request a replacement by phone, **PLAN AHEAD**, two business days may be needed to complete this process.

For disability & FMLA documents... Your doctor may require an office appointment in order to complete these documents. If not, please allow 30 days to have these forms completed. Please anticipate a fee for this service.

For test results... If your physician orders tests to be performed prior to your appointment, please do so 7 to 10 days **prior**, so these results can be shared and discussed at the time of your appointment. Your physician may order lab test or x-rays **following** your appointment. Please allow 7 to 10 days to receive these results. Your physician will contact you by phone with abnormal results in a timely fashion. If your results are within normal limits, you will receive notification via US mail.

Appointment Information... We require 24-hour notice. We have a 24-hour cancellation line for your convenience. For missed appointments we charge \$25 for a follow-up and \$88 for a new patient appointment.

For medical records... When requesting records from our office, please allow up to 30 days for processing.

Thank you for your consideration.
