NEW PATIENT HISTORY AND PHYSICAL QUESTIONNAIRE

NAME: _____ **Age:**_____ **DATE:** _____

INSTRUCTIONS: In **section 1** please check off all of the symptoms you have had in the past 4 weeks. Feel free to add any symptoms not listed. In **section 2** please check off past and present medical problems and surgeries. Again, feel free to add any problem not listed. In **section 3**, fill out your social history and habits and family history. Finally in **section 4**, please list all of your medications, doses and when you take them. Include all over-the-counter medications, herbal therapies and vitamins. Please be as complete as possible so we can spend more of our time together discussing your current problems.

Section 1: REVIEW OF SYSTEMS

had this problem in the **last 4 weeks**

CONSTITUTIONAL **notes**
- ☐ fever
- ☐ chills
- ☐ weight gain
- ☐ weight loss
- ☐ fatigue
- ☐ weakness
- ☐ night sweats
- ☐ Other

EYES
- ☐ double vision
- ☐ blurred vision
- ☐ when was you last eye exam?
- ☐ Other

EARS
- ☐ decreased hearing
- ☐ ear pain
- ☐ ringing
- ☐ Other
- ☐

NOSE
- ☐ congestion
- ☐ bleeding
- ☐ sinus pain
- ☐ do you snore?
- ☐ Other

THROAT/MOUTH
- ☐ pain
- ☐ hoarseness
- ☐ dental problems
- ☐ neck pain
- ☐ Other

PULMONARY SYSTEM
- ☐ cough
- ☐ shortness of breath
- ☐ ever stop breathing during sleep?
- ☐ do you dose-off during the day easily?
- ☐ Other

CARDIAC SYSTEM
- ☐ chest pain
- ☐ palpitations
- ☐ ankle swelling
- ☐ night time urination

GASTROINTESTINAL SYSTEM **notes**
- ☐ indigestion
- ☐ heart burn
- ☐ abdominal pain
- ☐ nausea
- ☐ excessive belching
- ☐ bloating
- ☐ excessive flatus (gas)
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoid pain
- ☐ Other
- ☐

UROGENITAL SYSTEM
- ☐ urine frequency
- ☐ urine burning
- ☐ urgency
- ☐ night time urination
- ☐ hesitancy
- ☐ dribbling
- ☐ incontinence
- ☐ weak stream
- ☐ discharge (vaginal or penile)
- ☐ sores/ulcers
- ☐ vaginal odor
- ☐ abnormal bleeding
- ☐ sexual problems
- ☐ menstrual problems
- ☐ Other
- ☐

MUSCULOSKELETAL SYSTEM
- ☐ joint pain
- ☐ joint swelling
- ☐ joint redness
- ☐ joint stiffness
- ☐ joint grinding
- ☐ muscle stiffness
- ☐ muscle weakness
- ☐ muscle pain
- ☐ morning stiffiness
- ☐ Other
- ☐

Section 1: REVIEW OF SYSTEMS, CONT.

SKIN SYSTEM **notes**

- ☐ rash
- ☐ lumps/bumps
- ☐ sores
- ☐ abnormal moles
- ☐ itching

NEUROLOGICAL SYSTEM

- ☐ numbness
- ☐ weakness
- ☐ pain
- ☐ headache
- ☐ dizziness
- ☐ loss of coordination
- ☐ loss of balance
- ☐ passing out
- ☐ tremor

PSYCHOLOGICAL/EMOTIONAL SYSTEM

- ☐ depression
- ☐ loss of interest in things you used to enjoy
- ☐ decreased motivation
- ☐ decreased energy
- ☐ agitation
- ☐ insomnia
- ☐ sleeping too much
- ☐ thoughts of dying
- ☐ irritable
- ☐ crying spells
- ☐ decreased appetite
- ☐ increased appetite
- ☐ hallucinations
- ☐ hearing voices
- ☐ worry a lot
- ☐ anxious
- ☐ obsessive or compulsive
- ☐ decreased libido/interest in sex

ENDOCRINE SYSTEM

- ☐ If you have Diabetes, are you checking your blood sugars? What are they running?
- ☐ cold intolerant
- ☐ heat intolerant
- ☐ hot flashes
- ☐ thirsty all the time
- ☐ urinate a lot
- ☐ hungry all the time

HEMATOLOGICAL SYSTEM

- ☐ fatigue
- ☐ easy bruising
- ☐ excessive bleeding

Section 2: PAST MEDICAL HISTORY

ILLNESS/PROBLEM **notes**

HEAD AND NECK ILLNESS

- ☐ glaucoma
- ☐ cataracts; any surgery?
- ☐ other eye surgery
- ☐ ear surgery
- ☐ mastoiditis
- ☐ Meniere Disease
- ☐ inner-ear infection
- ☐ chronic sinusitis
- ☐ chronic nasal allergies
- ☐ nasal polyps
- ☐ nose or sinus surgery
- ☐ dental surgery
- ☐ tonsillectomy
- ☐ carotid artery surgery

PULMONARY ILLNESSES/PROBLEMS

- ☐ asthma
- ☐ chronic bronchitis
- ☐ emphysema
- ☐ interstitial lung disease
- ☐ pneumonia
- ☐ valley fever
- ☐ tuberculosis

CARDIAC ILLNESSES/PROBLEMS

- ☐ heart attack; when?
- ☐ angina (heart pain)
- ☐ cardiac stress test
- ☐ coronary angiography (heart cath)
- ☐ heart bypass surgery; when?
- ☐ other heart surgery
- ☐ heart murmur
- ☐ heart failure
- ☐ hypertension (high blood pressure)
- ☐ pericarditis

NEUROLOGICAL SYSTEM

- ☐ stroke
- ☐ TIAs (pre-stokes)
- ☐ neuropathy
- ☐ carpal tunnel syndrome
- ☐ multiple sclerosis
- ☐ epilepsy/seizures
- ☐ Parkinson's disease
- ☐ vitamin B12 deficiency
- ☐ migraine headaches
- ☐ tension headaches
- ☐ cluster headaches
- ☐ sinus headaches
- ☐ dementia (eg Alzheimer's)

Name (print): _____

Date: _____

PAST MEDICAL HISTORY CONTINUED

GASTROINTESTINAL SYSTEM **notes**

- ☐ esophagitis/reflux/GERD
- ☐ hiatal hernia
- ☐ stomach or duodenal ulcer
- ☐ Gastritis or duodenitis
- ☐ colon polyps, if so, when was your last colonoscopy?
- ☐ diverticulosis
- ☐ Colitis (Crohn's or Ulcerative)
- ☐ Giardia
- ☐ Hemorrhoids (any surgery?)
- ☐ stomach or bowel surgery
- ☐ gall stones/surgery
- ☐ pancreatitis
- ☐ hepatitis
- ☐ jaundice
- ☐ spleen problem/surgery
- ☐ groin hernia/surgery
- ☐ ventral or umbilical hernia/surgery
- ☐ Appendicitis/surgery
- ☐ Other

BREASTS

- ☐ breast cancer/surgery
- ☐ fibrocystic breast disease
- ☐ breast biopsies
- ☐ last mammogram
- ☐ Other

MUSCULOSKELETAL ILLNESS/PROBLEM

- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ gout
- ☐ lupus
- ☐ scleroderma
- ☐ fibromyalgia
- ☐ joint surgery, which ones and when?
- ☐ broken bones, which ones and when?
- ☐ herniated disc
- ☐ other back problems
- ☐ Raynaud's Disease
- ☐ foot problems
- ☐ Other

DERMATOLOGICAL ILLNESS/PROBLEM

- ☐ eczema
- ☐ psoriasis
- ☐ seborrheic dermatitis
- ☐ warts
- ☐ melanoma
- ☐ basal cell skin cancer
- ☐ squamous cell skin cancer
- ☐ actinic keratosis (pre-cancer sun damage)
- ☐ athlete's foot
- ☐ Other

PSYCHIATRIC ILLNESS/PROBLEM **notes**

- ☐ depression
- ☐ anxiety disorder
- ☐ panic disorder
- ☐ manic depressive or bipolar disorder
- ☐ schizophrenia
- ☐ obsessive/compulsive disorder
- ☐ Other

UROGENITAL ILLNESS/PROBLEM

- ☐ frequent bladder infections
- ☐ kidney infection
- ☐ kidney stones
- ☐ other kidney problems
- ☐ incontinence
- ☐ bladder surgery
- ☐ kidney surgery
- ☐ prostate surgery
- ☐ kidney cancer/surgery
- ☐ bladder cancer/surgery
- ☐ prostate cancer/surgery
- ☐ ovarian cancer/surgery
- ☐ uterine/endometrial cancer
- ☐ Hysterectomy: with or w/o ovary removal?
- ☐ cervical cancer/surgery
- ☐ Genital warts
- ☐ herpes genitalia
- ☐ gonorrhea
- ☐ chlamydia
- ☐ syphilis
- ☐ HIV/AIDS
- ☐ PMS (premenstrual tension syndrome)
- ☐ endometriosis
- ☐ impotence
- ☐ pregnancy (list dates, child's sex, vaginal delivery or C-section, and complications)
- ☐ miscarriages & abortions (list dates and how many weeks)
- ☐ menopause (age of onset)
- ☐ last pap smear (month and year)
- ☐ Other

ENDOCRINE ILLNESS/PROBLEM

- ☐ hypothyroid
- ☐ hyperthyroid
- ☐ diabetes
- ☐ menopause
- ☐ Thyroid surgery (when?)
- ☐ Other

HEMATOLOGY/LYMPHATIC SYSTEMS

- ☐ anemia
- ☐ bleeding disorder
- ☐ hypercoagulable disorder
- ☐ lymphoma
- ☐ Hodgkin's disease
- ☐ leukemia
- ☐ Other

Name (print): _____ **Date:** _____

Section 3: SOCIAL HISTORY AND HABITS (check all that apply)

Yes/no ***Used to*** smoke: How many packs per day? _____ How many years did you smoke? _____ When did you quit? ___

Yes/no ***Currently*** *smoke*: How many packs per day? _____ How many years have you smoked? _____

Yes/no Did you ***used to*** drink alcohol: How many days per week? _____ When you did drink, how many drinks did you usually drink in one day? _____ What would be the most that you would drink in one day? _____ When did you quit? _____

Yes/no ***Currently*** drink alcohol: How many days per week? _____ When you do drink, how many drinks do you usually drink in one day? _____ What would be the most that you would drink in one day?_____

Yes/no Ever inject recreational drugs What years?
Yes/no Currently inject recreational drugs
Yes/no Any HIV or Hepatitis risk factors? (circle all that apply: used IV drugs, homosexual intercourse, blood transfusion, sex with a drug user or prostitute, more than 5 sexual partners since 1968) Do you want an HIV test? Yes or No
Yes/no Occupation history (list occupations and any chemical exposures):

Do you have a living will? Yes/no Do you have a medical power of attorney? Yes/no Who? _____
Do you have a durable power of attorney for your finances? Yes/no Who?_____
Circle all that apply: single, married, divorced, widowed, gay or lesbian
How important is a religious faith to your health? (circle one) Not at all, A little, Medium, A lot

family members	alive or dead? (A/D)	current age or age of death	CHECK BELOW EACH ILLNESS FOR EACH FAMILY MEMBER								
			heart disease	asthma	cancer	type of cancer	stroke	high blood pressure	high cholesterol	diabetes	other
Father											
Mother											
Siblings: (names)	Alive or dead	age	Heart disease	Asthma	Cancer	Type of cancer	Stroke	High blood pressure	High cholesterol	Diabetes	Other
Children:	A or D	Age	Heart disease	Asthma	Cancer	Type of cancer	Stroke	High blood pressure	High cholesterol	Diabetes	Other

Name (print): _____ **Date:**_____

SECTION 4: MEDICATIONS, VITAMINS AND HERBALS

Medication Allergies: ☐ None, ☐ Penicillin, ☐Sulfa, ☐ Other _____

Please list all of your medications (prescription and non-prescription), vitamins, herbal, and homeopathic remedies.

MEDICATION	**DOSE OF EACH PILL** (in mg, grams, units, etc.)	**NUMBER OF PILLS YOU TAKE AND WHEN YOU TAKE THEM.**
EXAMPLE: TYLENOL	500 mg (Extra-Strength)	2 pills at 8 am and 10 pm and sometimes 2 pills 4 times a day as needed.

Name (print):_____ Date:_____

2013 Patient Information Sheet – Skyline Internal Medicine

Who is your physician? ☐ **Anisimova** ☐ **Ghincea** ☐ **Schultz** ☐ **Sebestyen** ☐ **Iryna** **New Patient?** ☐ **Y** ☐ **N**

Patient Name_____**Prefer to be called:** _____
First Name **Middle Initial** **Last Name**

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Home phone: (____)_____ **Work phone: (____)**_____ **Cell Phone: (____)**_____

SSN:_____ **Marital Status:** _____ **Date of Birth:**_____ **Gender:** ☐ **F** ☐ **M**

Employers Name:_____ **Occupation:**_____

New Patients to the Practice: Who may we thank for your referral to our practice? Please check one:
Referred by: ☐ Dr. (_____) ☐ Family Member ☐ Friend ☐ Insurance Directory ☐ Mailer ☐ Our Website
☐ Other (Please Specify): _____

HEALTH INSURANCE INFORMATION - OR - ☐ SELF PAY

(Although we have copied your insurance card, we still need you to complete all of the information below)

PRIMARY INS: _____ **Eff. Date:**_____ **Copay Amt.: $**_____

Policy Holder Name: _____**DOB:** _____ **M /F:** _____

If same as above, please write "same" on this line & disregard the primary insurance section

Policy Holder Address (if different from above):_____

Policy Holder Employer: _____**Employer Ph#:** (_____) _____

Relationship to Policy Holder: _____**Policy Holder SS#:** _____

Policy Holder ID: _____**Group #:**_____

SECONDARY INS: _____(if Medicare is 2ndary, please read below) **Eff. Date**:_____

Medicare Patient's Only: If Medicare is your secondary insurance, please list a reason why Medicare is the secondary insurance. Information needed in order to file your claim with Medicare. Reason: _____

Policy Holder Name: _____**DOB:** _____ **M /F:** _____

Policy Holder Address (if different from above):_____

Policy Holder Employer: _____**Employer Ph #:** (_____) _____

Relationship to Policy Holder: _____**Policy Holder SS#:** _____

Policy Holder ID: _____**Group#:**_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship to Patient:**_____
Home Ph#:_____**Work Ph#:**_____**Alt. Ph#**_____

Do you have a living will or a durable power of attorney? (circle one) Yes No

****If yes, please provide the office a copy****

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize **HealthONE/Skyline Internal Medicine** to render needed treatment to the above named patient.
2. I authorize **HealthONE/Skyline Internal Medicine** to release any information required for payment of claims.
3. I authorize my insurance benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services and I hereby authorize the release of pertinent medical information to insurances.
4. I understand that I am responsible for all charges incurred through **HealthONE/Skyline Internal Medicine** Payment is expected at the time of my visit.

Email Address: _____ ☐ **NO EMAIL**

Signature:_____ **Date:**_____

Skyline Internal Medicine

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following treatment::

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **HealthONE /Skyline Internal Medicine** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **HealthONE / Skyline Internal Medicine** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **HealthONE /Skyline Internal Medicine.**

I acknowledge that I have been given the **HealthONE / Skyline Internal Medicine** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Patient (or Responsible Party) Signature **Date**

How Can We Reach You?

HealthONE Clinic Services

PHONE MESSAGE CONSENT

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name: _____

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will *NOT* leave messages with anyone except the patient or legal guardian.
- We will *NOT* leave any messages on a voice mail or answering machine.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____ give HealthONE my permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My **Home** answering machine: #_____ Initials: _____

My **Cell** voice mail: #_____ Initials: _____

My **Office/Work** voice mail: #_____ Initials: _____

Other Contacts:

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Signature: _____ Date: _____