RETURN 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 list any problems or questions you have for today.

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

EYES

- double vision
- blurred vision
- When was your last eye exam?

EARS

- decreased hearing
- ear pain
- ringing

NOSE

- congestion
- bleeding
- sinus pain
- snoring

THROAT/MOUTH

- pain
- hoarseness
- dental problems
- neck pain

PULMONARY SYSTEM

- cough
- shortness of breath
- Ever stop breathing during sleep?
- Do you dose-off easily during the day?

CARDIAC SYSTEM

- chest pain
- palpitations
- ankle swelling
- night time urination

GASTROINTESTINAL SYSTEM **notes**

- indigestion
- heart burn
- abdominal pain
- nausea
- excessive belching
- excessive flatus (gas)
- bloating
- diarrhea
- constipation
- hemorrhoid pain

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

MUSCULOSKELETAL SYSTEM

- joint pain
- joint swelling
- joint redness
- joint stiffness
- joint grinding
- muscle stiffness
- muscle weakness
- muscle pain
- morning stiffness

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 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: ______________________________

Date: _________________________

PAST MEDICAL HISTORY CONTINUED

GASTROINTESTINAL SYSTEM **notes**

- esophagitis/reflux/GERD
- hiatal hernia
- stomach or duodenal ulcer
- gastritis or duodenitis
- colon polyps
- diverticulosis/diverticulitis
- Colitis (Crohn's or Ulcerative Colitis)
- 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
- Appendectomy

BREASTS

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

MUSCULOSKELETAL ILLNESS/PROBLEM

- osteoarthritis
- rheumatoid arthritis
- gout
- pseudogout
- 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

DERMATOLOGICAL ILLNESS/PROBLEM

- eczema
- psoriasis
- seborrheic dermatitis
- warts
- Melanoma (malignant mole)
- basal cell skin cancer
- squamous cell skin cancer
- actinic keratosis (pre-cancer sun damage)
- athlete's foot

PSYCHIATRIC ILLNESS/PROBLEM **notes**

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

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)

ENDOCRINE ILLNESS/PROBLEM

- hypothyroid
- hyperthyroid
- diabetes
- menopause
- thyroid surgery

HEMATOLOGY/LYMPHATIC SYSTEMS

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

Name:_____________________________ **Date:** ________________________

<u>Section 3: SOCIAL HISTORY AND HABITS</u> (circle 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 would you **usually** drink in one day? ________ What would be the **most** 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** 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: use IV drugs, homosexual intercourse, blood transfusion, sex with a drug user or prostitute, more than 5 sexual partners since 1968)
Are you interested in getting and HIV blood test? (circle) 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? 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

HEALTH MAINTENANCE AND PREVENTATIVE MEDICINE:

When was your last tetanus shot?
Have you ever had a pneumonia vaccine?
Have you ever had a shingles vaccine?
Ever had a colonoscopy? When?

Ever have a bone density? When?
Have you ever had a mammogram? When was the last one?
Last PAP test?
Ever had a PSA test? When?

Do you have any family history of cancer, diabetes or heart disease in you parents, siblings or children? If so, who and how old were they?

Below this line for the doctor to fill out:

PHYSICAL EXAM:

BP:_______ HR:_______ RR: ______ Weight: _____ Height: _____ BMI: ______ Waist Circ. ______

GENERAL/PSYCH:

HEENT:

RESP:

CARDIO:

GI:

CHEST/BREASTS:

GU:

MUSCULOSKEL:

NEURO:

SKIN:

IMPRESSION:

Name (Print):_________________________________ Date: ___________

2013 Patient Information Sheet – Skyline Internal Medicine

Who is your physician? 5 Anisimova 5 Ghincea 5 Schultz 5 Sebestyen 5 Iryna New Patient? 5 Y 5 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: 5 F 5 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:** ______________________