

WEST ATLANTA INTERNAL MEDICINE
6128 Prestley Mill Rd. Suite
Douglasville, GA 30134

Date: _____/_____/_____

PATIENT INFORMATION RECORD (please print answers)

Name _____ Nickname _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

S.S.# _____ Age _____ Date of Birth ____/____/_____ E-mail _____

Sex _____ Marital Status _____ Student? yes no School _____

Employer's Name (Patient's or Legal Guardian's) _____

Employer's Address _____ Phone _____

Spouses'/Other Parent's Name _____ Employer _____ Phone _____

Physician _____ Phone _____ Other M.D. _____ Phone _____

Referred by _____

Were you injured while working? (Workers' Comp) NO YES. Date of Injury ____/____/_____

Accident? NO YES. Type: Motor Vehicle, Other _____ Date of Accident ____/____/_____

Are you represented by an attorney? NO YES.

Attorney's Name _____ Attorney's Phone # _____

FINANCIAL INFORMATION

Check one: Who will be responsible for your account? Self Spouse Father Mother Other _____

Responsible Person's Name _____ Soc Sec # _____ Date of Birth ____/____/_____

Address _____ Phone _____ Work Phone _____

Employer's Name _____ Employer's Address _____

Name of Insured (if different from Responsible Person) _____

Relationship _____ S.S.# _____ Date of Birth ____/____/_____

Address _____ Phone _____ Work Phone _____

Employer's Name _____ Employer's Address _____

Medical Ins. Co. _____ ID# _____ Group:# _____

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we will assist you in filing claims.

I, the undersigned, hereby acknowledge that it is the policy of the office that all payments are made at each visit and I am responsible for payment of all services for the above patient to the physician, rendered not covered by Medicare assignment, Medicaid, workman's compensation, or other benefits agreed by the provider of such services. _____ **initial**

I authorize release of any medical information necessary to process this claim to third party carriers and also certify that the information contained herein is correct. _____ **initial**

I authorize payment of medical benefits to the physician or supplier for services rendered. _____ **initial**

Lifetime Authorization – Medicare Patients Only

I request that payment of authorized Medicare benefits to be made to the physician or supplier for any services rendered to me. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. _____ **initial**

_____/_____/_____
Patient's Signature (Parent or Legal Guardian) Date

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

General:

Name:	Birthdate:	SS #:
-------	------------	-------

Date of your last complete physical exam?	Date of your last chest X-ray?
Date of your last cholesterol screening?	Date of your last dental exam?
Date of your last eye exam?	Date of your last sigmoidoscopy?

Women:	Men:
Date of last mamogram?	Date of last PSA?
Date of last pap smear?	Date of last rectal/prostate exam?

Immunizations:		Pneumonia	Date:
Measles - Mumps - Rubella (MMR)	Date:	Hepatitis B	Date:
Tetanus and diphtheria toxoids (Td)	Date:	Influenza	Date:

Past Medical History: (check those that apply)

<input type="checkbox"/> AIDS or HIV +	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood or Plasma Transfusions	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Infectious Mononucleosis	<input type="checkbox"/> Polio	<input type="checkbox"/> Whooping Cough

Hospital / Surgical History:

Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

Allergies:

Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction.

Medications:

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1)	4)	7)
2)	5)	8)
3)	6)	9)

Social History:

Occupation: _____ Marital Status: _____

Do you exercise regularly? YES NO What type? _____ How often? _____

I have never smoked. YES NO I currently smoke _____ packs per day. I have smoked for _____ years.

I formerly smoked but stopped in: _____ (list year) Do you wear seat belts? YES

Do you use other forms of tobacco? YES NO Do you use illicit drugs? YES NO Do you drink alcohol? YES

How often/how much? _____ How often/how much? _____ How often/how much? _____

Do you have any risk factors for HIV infection? YES NO Have you ever been exposed to anyone with tuberculosis? YES

Have you had excessive exposure to sun because of your work or recreation? YES

Are you currently experiencing unusual stress? YES NO Explain: _____

Are there any environmental risks involved in your job or home environment? YES NO Explain: _____

Family History:

Relationship	Relationship	Relationship
Anemia	Epilepsy	High cholesterol
Asthma	Glaucoma	Kidney disease
Obesity	Leukemia	Thyroid disease
Cancer	Depression	High blood pressure
Diabetes	Heart disease	Alcohol problems
Stroke	Lung disease	Bleeding Tendency

Present Age or Age of Death: _____ Mother: _____ Father: _____

Sibling #1 _____ Sibling #2 _____ Sibling #3 _____

Women Only: Menstrual Period Onset: _____ Regular? YES NO Date last period began: _____

Age at menopause: _____ Difficulty with periods? YES NO Specify: _____

Pregnancies: No. of children: _____ Born Alive: _____ Cesarean: _____ Premature: _____ Stillborn: _____ Miscarriages: _____

Describe complications:

Please check all conditions you currently have or have had:

General Questions	Cardiovascular	Kidneys & Urinary Tract	Musculoskeletal
Weight loss	Angina Chest pain	Blood in urine	Anemia Arthritis
Weight gain	Leg cramps Murmurs	Brown urine	Back pain Bursitis
Change in sleep patterns	Ankle swelling	Dribbling after urination	Gout Joint a
Change in activity capacity	Awakening at night short of breath & getting out of bed	Painful urination	Neck pain Tendin
Neurologic and Psychiatric	Cardiac catheterization	Excessive thirst	Abnormal Blood Counts
Anxiety	Cold hands or feet	Involuntary urination/incontinence	Blood clots in legs/lungs
Headaches	Congenital heart defects	Urinating frequently (day)	Bone Marrow Biopsy
Depression	Dizziness when standing	Urinating frequently (night)	Easy Bleeding
Meningitis	up quickly	Urine hesitancy	Easy bruising
Paralysis	Heart attacks	Weak flow	Joint swelling
Seizure	Heart failure	Frequent bladder infections	Morning stiffness
Stroke	High or low blood pressure	Kidney disease	Muscle aches
Tingling	Irregular heart rate	Kidney stone	Gastrointestinal
Tremors	Purple fingers or lips	Endocrine	Diarrhea Gallstc
Memory Loss	Leg pain that resolves with rest	Diabetes Sickle cell	Reflux Vomiti
Fainting spells, dizziness	Heart palpitations	Abnormal body hair	Ulcers Heartb
Head injuries	Varicose veins	Changes in skin texture	Hepatitis Indiget
Blackouts or near blackouts	Respiratory	Cold intolerance	Abdominal pain
Change in sensation anywhere on your body	Pleurisy Wheezing	Heat intolerance	Anal fissures
Localized weakness or numbness	Asthma	History of "borderline" diabetes	Black tarry stools
Ears, Eyes, Nose & Throat	Breathlessness when lying flat	Increased loss of hair	Vomiting blood
Hay fever	Prolonged cough	Rheumatism	Constipation
Glaucoma	Coughing up blood	Thyroid disease	Nausea
Polyps	Emphysema	Male & Female	Problems swallowing
Allergy	Shortness of breath	Painful sexual intercourse	Hiatal Hernia
Cataracts	Tuberculosis	Loss of sexual interest	Intestinal obstruction
Goiter	Pneumonia	Unprotected sex	Liver disease
Hoarseness	Frequent infections (bronchitis)	Groin itching	Hemorrhoids
Double vision	Skin	Sexually transmitted diseases	Red blood after bowel movements
Gum problems	Abscess Dandruff	Males Only	Females Only
Eye problems	Acne Oily skin	Hernia Sterility	D + C Hot fla
Ear Infections	Boils Rashes	Bloody ejaculation	Hernia Fibroid
Glasses/contacts	Hives Dry skin	Inability to complete intercourse	Abn. bleeding between cyc
Hearing Loss	Lumps Psoriasis	Lump on testicle	Abnormal pap smear
Ear discharge/pain	Jaundice	Penile discharge	Bleeding after intercourse
Frequent nosebleeds	Athlete's foot	Premature ejaculation	Complications w/ pregnanc
Ringin in your ears	Excessive body odor	Problems maintaining or keeping an erection	PMS
Sinus infectic	Excessive sweating	Prostate disease	Endometriosis
Swollen glands	Fungal infections	Sores on penis or warts	Heavy bleeding during cycl
	Nail problems	Testicular pain	Discharge from breast
	Moles- irregular	Testicular swelling	Ovarian cysts
	Moles - change/new		Pelvic Inflammatory Disease
			Postmenopausal symptom
			Vaginal discharge
			Vaginal Dryness
			Vaginal warts