Asheville Internal Medicine

Patient Name: _____ Sex: __ Age: ____ Date of birth: _____

Address: _____

Phone (H): (___) _____ (W) (___) _____ Social Security #: _____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Work Status: ☐ Full time ☐ Part time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Duty

Student Status: ☐ Full time ☐ Part time ☐ Not Student

Patient's Employer & Address: _____

Spouse's Employer & Address: _____

Emergency Contact (Name, Address, Phone Number): _____

_____ Relationship to patient: _____

If you are ill and cannot take care of yourself, who will help you? _____

Who referred you to this office? _____

All professional services rendered are charged to the patient. We request that you pay for services when rendered unless other arrangements are made in advance. You will be given a copy of your encounter form which contains all information needed to file with your insurance company. The **Patient is Responsible For All Charges, Regardless of Insurance Coverage.**

Medicare ID #_____ Policy Holder Name _____

Other Insurance Company _____ ID # _____

Policy Holder Name _____ Group # _____

Address Where Claim to be mailed _____

Other Ins Company _____ ID # _____

Policy Holder Name _____ Group # _____

Address where claim to be mailed _____

AUTHORIZATION TO RELEASE INFORMATION: I give my authorization for my medical records to be sent to other doctors I may be seeing. I authorize the use of photostatic copy of this agreement and authorization in lieu of original when necessary.

_____ _____

Signature of Patient or Responsible Party Date

AUTHORIZATION FOR PAYMENT: I authorize the release of my medical information necessary to process the claim and request payment of Medicare benefits to the party who accepts assignment. I understand that I am responsible for all charges, regardless of insurance coverage.

_____ _____

Signature of Patient or Responsible Party Date

Social/Cultural History:

Do you have any children? _____ If so, how many? _____
Are there any specific personal problems or concerns you would like to discuss? _____
Are there any cultural or religious concerns that you have related to our delivery of care? _____
Are there any specific household problems that you would like to discuss? _____
Are there any financial issues that you would like to discuss? _____
Have you had any occupational changes? ☐ Disabled ☐ Unemployed ☐ Other_____
Have you experienced a recent death of a family member? ☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Other
Any other social issues that you would like to discuss? _____

Communication:

Language of preference: _____
Any vision problems that affect your communication. Y N. If yes, please describe_____
Any Hearing Problems: Y N. If yes, please describe: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (Including exact dosage & frequency)

Name	Dosage	How often	Name	Dosage	How often
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		

LIST ALLERGIES TO MEDICINES: _____

ARE YOU ALLERGIC TO LATEX, IODINE, OR X-RAY DYE? (PLEASE CIRCLE) Y N

Personal Medical History: Do you or have you ever had any of the following? Please explain

☐ Eye Problems _____
☐ Ulcer/Colitis/Bowel _____
☐ Thyroid Disease _____
☐ Diabetes _____
☐ High Cholesterol _____
☐ Neurological Disease _____
☐ Blood Disease (Anemia/Leukemia) _____
☐ Skin Disease _____
☐ Depression/Anxiety _____
☐ Abuse _____
☐ Illegal Prescription Drug Abuse _____
☐ **GYN Problems (for women only)** _____
☐ Kidney/Bladder Problems _____
☐ Ear Problems _____
☐ Sinus Problems _____
☐ Respiratory Disease (Pneumonia, Bronchitis, etc) _____
☐ High Blood Pressure _____
☐ Heart Disease (Heart attack, chest pain, ect) _____
☐ Stroke/ TIA _____
☐ Circulatory Disease _____
☐ Bone/Joint Disease _____
☐ Alcohol Abuse _____
☐ Other mental health disorders _____
☐ **Prostate Problems (for men only)** _____

Please list past surgeries, hospitalizations or injuries:

Operations/Illness	Date	Physician/Hospital

Family Medical History: (Please check if grandparent, parent, sibling or child has a history with these health issues)

- ☐ Heart Disease _____
- ☐ High BP _____
- ☐ Stroke/TIA _____
- ☐ Diabetes _____
- ☐ Thyroid _____
- ☐ Alcohol Abuse _____
- ☐ High Cholesterol _____
- ☐ Lung Disease _____
- ☐ Asthma _____
- ☐ Anemia/Blood _____
- ☐ Alzheimer's Disease _____
- ☐ Drug Abuse _____
- ☐ Glaucoma _____
- ☐ Kidney Disease _____
- ☐ Breast Cancer _____
- ☐ Cancer _____
- ☐ Depression/Anxiety _____
- ☐ Other mental health disorder _____
- ☐ Any other family medical issues _____

Tobacco History:

Do you currently use tobacco products? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No

If yes, please indicate the type of tobacco products below:

- ☐ Cigarettes — Packs per day (20 cigarettes/pack): _____
- ☐ Pipe — Bowls per day: _____
- ☐ Cigars — Number per day: _____
- ☐ Smokeless — Cans/pouches per day: _____
- ☐ Other tobacco products (orbs, strips, sticks, hookah, etc) — Amount per day: _____

Medication used in previous quit attempt:

- ☐ No medication
- ☐ Nicotine patch
- ☐ Nicotine gum
- ☐ Nicotine lozenge
- ☐ Nicotine nasal spray
- ☐ Nicotine oral inhaler
- ☐ Varenicline
- ☐ Bupropion
- ☐ Other: _____

Readiness to Quit:

- ☐ Not interested in quitting
- ☐ Would like to quit sometime (but not within the next month)
- ☐ Would like to quit now or soon (within the next month)

Other smokers in household? ☐ Yes ☐ No

Fall Risk Assessment:

Have you had any falls in the past year? ☐ Yes ☐ No
Do you have any worries about falling or feel unsteady when standing or walking? ☐ Yes ☐ No
If so, please explain _____

Assessment of Risky Health Behaviors:

Do you drink alcohol? ☐ Y ☐ N # of drinks at a time _____ How many days per week? _____
When was the last time you had more than 4-5 drinks in one day? ☐never ☐in past 3 months ☐ over 3 months
How often do you exercise? ☐ never ☐ rarely ☐1 to 3 times/month ☐ 1 to 3 times/ week ☐ 4 to 6 times/week ☐ 7 days/week
Are you sexually active? ☐ Y ☐N Do you have any sexual concerns? ☐ Y ☐ N Have you ever been treated for a sexually transmitted disease? ☐ Y ☐ N
Do you have any reason to suspect that you have been exposed to HIV or AIDS? ☐ Y ☐ N
Do you handle and control the stress in your life? ☐ Y ☐ N
Do you sleep well at night? ☐ Y ☐N How many hours? _____
Have you experienced a serious life event recently (death, divorce, new job, moved, etc?) ☐ Y ☐ N
If yes, please explain _____

Depression Assessment
In the past month:
Have you often been bothered by feeling down, depressed or hopeless? ☐ Y ☐ N
Have you often been bothered by little interest or pleasure in doing things? ☐ Y ☐ N
Are you generally happy with your life and your current health? ☐ Y ☐ N

When was your last exam? (Indicate Year and Results)

EKG: _____
Physical Exam: _____
Chest X-ray: _____
Pneumonia Vaccine: _____
Tetanus Vaccine: _____ ☐Td or ☐ Tdap
Zostavax: _____

Colonoscopy: _____
Mammogram: _____
Pap Smear: _____
Bone Density: _____
Flu Vaccine: _____
Dental Exam: _____

Advance Care Planning:

Do you current have any of the following?
☐ Living Will; ☐Five Wishes; ☐ DNR; ☐ MOST; ☐ Health Care Power of Attorney; ☐Other _____

Review of Systems:

☐ **Constitutional**		☐ **ENT**		☐ **EYES**	
Good General Health	Y N	Hearing loss or ringing	Y N	Wear glasses/contacts	Y N
Recent Weight Changes	Y N	Sinus Problems	Y N	Blurred/double vision	Y N
Night Sweats/ Fever	Y N	Nose Bleeds	Y N	Eye disease or injury	Y N
Fatigue/Weakness	Y N	Sore Throat	Y N	Glaucoma	Y N
Sleep Problems	Y N				
☐ **Cardiovascular**		☐ **Respiratory**		☐ **Musculoskeletal**	
Chest pain	Y N	Shortness of breath	Y N	Muscle pain or cramps	Y N
Palpitations	Y N	Cough	Y N	Stiffness/swelling joints	Y N
Heart Trouble	Y N	Wheezing/Asthma	Y N	Joint Pain	Y N
Swelling Hands/Feet	Y N	Coughing up blood	Y N	Trouble walking	Y N

☐ **Neurological**

Frequent headache	Y N
Paralysis or tremors	Y N
Convulsions/seizures	Y N
Numbness/tingling	Y N

☐ **Hematologic/Lymphatic**

Bruise easily	Y N
Enlarged glands	Y N

☐ **Gastrointestinal**

Nausea/vomiting	Y N
Abdominal pain	Y N
Constipation	Y N
Diarrhea	Y N
Rectal bleeding	Y N

☐ **Integumentary (Skin/Breast)**

Change in hair or nails	Y N
Rashes or itching	Y N
Breast Lump	Y N
Breast pain/discharge	Y N

☐ **Psychiatric**

Insomnia	Y N
Confusion/Memory loss	Y N
Depression	Y N

☐ **Endocrine**

Excessive thirst	Y N
Thyroid disease	Y N

☐ **Genitourinary**

Blood in urine	Y N
Kidney stones	Y N
Testicle pain	Y N
Abnormal periods	Y N

_____ _____

Patient Signature Date

_____

Patient Printed Name

_____ _____

Physician Signature Date