Individual Medical Care
Your doctor is in.

DATE_____

Please fill out this form, print it, and bring it to your next appointment

PATIENT MEDICAL HISTORY

NAME_____ DATE OF BIRTH_____

PREVENTIVE MEDICINE- Please List the Year You Had the Following Performed

_____Bone Density Test
_____Cardiac Catheterization
_____Carotid Ultrasound
_____Chest X-Ray
_____Colonoscopy
_____Dilated Eye Exam
_____EGD
_____EKG
_____Echocardiogram
_____Flu Vaccine
_____H1N1 Vaccine
_____Hepatitis B Vaccine
_____Holter Monitor
_____ICG
_____Mammogram
_____PFTs
_____PPD
_____PSA (Men Only)
_____PAP (Women Only)
_____Pneumonia Vaccine
_____Rectal Exam
_____Shingles Vaccine
_____Stress Test
_____Tetanus Booster

MEDICAL CONDITIONS- Please check all which apply

CANCER-Please List Year Diagnosed

☐ Breast R L _____
☐ Cervical _____
☐ Colon _____
☐ Esophageal _____
☐ Kidney _____
☐ Leukemia _____
☐ Lung _____
☐ Melanoma _____
☐ Multiple Myeloma _____
☐ Pancreas _____
☐ Prostate _____
☐ Rectal _____
☐ Skin Cancer _____
☐ Stomach _____
☐ Thyroid _____
☐ Uterine _____

CARDIOVASCULAR

☐ Atrial Fibrillation
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Heart Attack
☐ Heart Murmur
☐ High Cholesterol
☐ High Blood Pressure
☐ Pacemaker
☐ Palpitations

CEREBRAL/NEUROLOGIC

☐ Alzheimer's Disease
☐ Carotid Artery Disease
☐ Dizziness
☐ Epilepsy
☐ Migraine Headache
☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizure Disorder
☐ Senile Dementia
☐ Stroke/CVA

GASTROINTESTINAL

- ☐ Barrett's Esophagus
- ☐ Colon Polyps
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Gastritis
- ☐ GERD/Acid Reflux
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Stomach Ulcer
- ☐ Ulcerative Colitis

GENITAL/URINARY

- ☐ Blood In Urine
- ☐ Endometriosis
- ☐ Enlarged Prostate
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Ovarian Cysts
- ☐ Prostatitis
- ☐ Recurrent Bladder Infections
- ☐ Urinary Incontinence
- ☐ Urinary Retention
- ☐ Uterine Fibroids

HEMATOLOGIC/VASCULAR

- ☐ Anemia
- ☐ Blood Clot/DVT
- ☐ Factor V Leiden Deficiency
- ☐ Leukemia
- ☐ Peripheral Artery Disease
- ☐ Varicose Veins

INFECTIOUS

- ☐ Herpes
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Tuberculosis

METABOLIC

- ☐ Anorexia
- ☐ Diabetes-Insulin Dependent
- ☐ Diabetes-Non Insulin Dependent
- ☐ Grave's Disease
- ☐ Obesity
- ☐ Overactive Thyroid
- ☐ Underactive Thyroid

ORTHOPEDIC

- ☐ Chronic Back Pain
- ☐ Degenerative Arthritis
- ☐ Degenerative Disk Disease
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Spinal Stenosis

PSYCHIATRIC

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Drug Addiction
- ☐ Schizophrenia

PULMONARY

☐	Asthma	☐	Obstructive Sleep Apnea
☐	Bronchitis	☐	Oxygen Use
☐	COPD	☐	Pneumonia
☐	Emphysema	☐	Pulmonary Embolism

VISUAL

☐	Blindness	☐	Glaucoma
☐	Cataracts	☐	Macular Degeneration

Have You Ever Had A Blood Transfusion?

No_____ Yes_____ Year_____

SURGICAL HISTORY- Please List the Year the Surgery was Performed

Circle Right or Left

☐	Abdominal Aneurysm	_____	☐	Gallbladder	_____
☐	Aortic Stent	_____	☐	Hemorrhoid	_____
☐	Appendectomy	_____	☐	Hernia	_____
☐	Breast Biopsy R L	_____	☐	Hip Replacement R L	_____
☐	Bypass Surgery	_____	☐	Hysterectomy	_____
☐	Carotid R L	_____	☐	Knee Replacement R L	_____
☐	Carotid Stent	_____	☐	Pacemaker	_____
☐	Cataract R L	_____	☐	Prostate/TURP	_____
☐	Cystoscopy	_____	☐	Tonsillectomy & Adenoids	_____
☐	Defibrillator/AICD	_____	☐	_____	
☐	_____		☐	_____	

FAMILY HISTORY- Please List Family Members Medical History

Father	☐	Alive at Age_____	☐	Deceased at Age _____	_____
Mother	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Brother	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Brother	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Brother	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Brother	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Sister	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Sister	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Sister	☐	Alive at Age_____	☐	Deceased At Age_____	_____
Sister	☐	Alive at Age_____	☐	Deceased At Age_____	_____

SOCIAL HISTORY

Marital Status	☐	Single	☐	Divorced	☐	Partner	
	☐	Married	☐	Widowed			
Education	☐	High School	☐	_____ Highest Grade	☐	GED	
	☐	College	☐	Masters	☐	Doctorate	
Occupation	☐	Employed	☐	Job Title _____	☐	Homemaker	
	☐	Unemployed	☐	Retired	☐	Disabled	

Cigarette Use

☐ Never Smoked

☐ Currently Smoking ____Cigarettes or Packs per Day
For How Many Years? _____

☐ Former Smoker _____Cigarettes or Packs per Day
For How Many Years? _____
Quit- How Many Years Ago? _____

Alcohol Use

☐ Does not consume alcohol

☐ Does consume alcohol
Type_____ Frequency_____

Illegal Drug Use

☐ Does not use illegal drugs

☐ Does use illegal Drugs
Type_____ Frequency_____ Quit_____

Caffeine Use (Coffee/Soda)

☐ Does not use Caffeine

☐ Does use Caffeine
Type_____ _____Cups/Cans per Day

MEDICATION LIST

1. Please list all current medications taken on a daily basis and as needed.
2. Please include medications prescribed by a doctor and any over the counter medications
3. Please write the name, dosage, and how often you take the medications.
4. Please notify our staff of any changes to your medication at each visit.
5. Please keep an updated list of medications with you at all times.

NAME OF MEDICATION	STRENGTH OF MEDICATION	HOW OFTEN

ALLERGIES TO MEDICATIONS

Please List the Name of the Medication and the Symptoms Associated

☐ No Known Drug Allergies

Medication	Allergic Symptoms

DATE_____

PATIENT REGISTRATION

FIRST NAME_____MIDDLE INITIAL____LAST NAME_____

STREET ADDRESS_____CITY/STATE/ZIP_____

HOME PHONE ( )_____WORK PHONE ( )_____EXT____

FAX NUMBER ( )_____CELL PHONE ( )_____

PATIENT SEX - MALE OR FEMALE (CIRCLE ONE) DATE OF BIRTH_____

PATIENT SOCIAL SECURITY NUMBER_____-_____-_____

PATIENT E-MAIL ADDRESS_____

PHARMACY NAME_____

PHARMACY ADDRESS_____

PHARMACY PHONE_____PHARMACY FAX_____

EMERGENCY CONTACT NAME_____ RELATIONSHIP_____

EMERGENCY CONTACT PHONE NUMBER_____

REFFERAL SOURCE - HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ ANOTHER DOCTOR - WHO? _____

☐ ANOTHER PATIENT - WHO? _____

☐ PHYSICIAN REFERRAL SOURCE

☐ YELLOW PAGES

☐ ADVERTISEMENT

☐ OTHER_____

ARE YOU CURRENTLY SEEING ANY OTHER PHYSICIANS? YES NO

IF YES, PLEASE LIST THE PHYSICIANS NAMES, AND THE REASON YOU ARE SEEING THEM.

DR._____ _____

DR._____ _____

DR._____ _____

DR._____ _____

IMC – INDIVIDUAL MEDICAL CARE
PATIENT CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH OPERATION

I,_____, understand that as part of my healthcare, (IMC – Individual Medical Care) originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and any plans for future care of treatment.

I understand that this information serves as:

- ☐ A basis for planning my care and treatment
- ☐ A means of communications among many health professionals who contribute to my care
- ☐ A source of information for applying my diagnosis and surgical information to my bill
- ☐ A means by which a third-party payer can verify that services billed were actually provided
- ☐ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with the notice of Information Practice that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ☐ The right to review the notice prior to signing the consent
- ☐ The right to object to the user of my health information for directory purposes
- ☐ The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare options

I understand that physicians or physicians group is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that organization has already taken action in reliance thereon, I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted in section 164.506 of the Code of Federal Regulations.

I understand that I am agreeing that IMC – Individual Medical Care has my permission to confirm my doctor's appointments on my answering machine or verbally to another household member.

I understand that IMC – Individual Medical Care may release information about me to family members, personal representatives, close personal friends, or any other person I identify. This medical information will be relevant to that person's involvement in my care or payment related to my care.

I further understand that IMC – Individual Medical Care reserves the right to change their notice and practices and prior implement, in accordance with section 164.520 of Code of Federal Regulations. Should physicians or physicians group changes their notice, they will send a copy of any revised to the address I've provided.

Signature of Patient_____Date_____
(or patient's personal Representative) Relationship to Patient_____

List below other names to whom we may release your health information, and their relationships. Please circle whether information should be limited or all information.

Name_____Relationship_____
Limited/Full

Name_____Relationship_____
Limited/Full

If you would like to change this information at any time, you must contact our office in writing as soon as possible.