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 EMAIL 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?

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

DR.____ _________________________

DR.____ _________________________

DR.____ _________________________

DR.____ _________________________

DATE__________

PATIENT MEDICAL HISTORY

NAME________________________ DATE OF BIRTH__________

PREVENTATIVE 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
_______PFT's
_______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
- ☐ Osteo-Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Spinal Stenosis
- ☐

PSYCHIATRIC

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

PULMONARY

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

VISUAL

- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ 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_______
- ☐ Aortic Stent _______
- ☐ Appendectomy _______
- ☐ Breast Biopsy R L _______
- ☐ Bypass Surgery _______
- ☐ Carotid R L _______
- ☐ Carotid Stent _______
- ☐ Cataract R L _______
- ☐ Cystoscopy _______
- ☐ Defibrillator/AICD _______
- ☐ ________________________
- ☐ Gallbladder _______
- ☐ Hemorrhoid _______
- ☐ Hernia _______
- ☐ Hip Replacement R L _______
- ☐ Hysterectomy _______
- ☐ Knee Replacement _______
- ☐ R L
- ☐ Pacemaker _______
- ☐ Prostate/TURP _______
- ☐ Tonsillectomy & Adenoids _______
- ☐ ________________________
- ☐ ________________________

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

INTERNAL MEDICINE CONSULTANTS OF YORK, INC.
PATIENT CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH OPERATION

I,____________________, understand that as part of my healthcare, (Internal Medicine Consultants of York , Inc.) originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, and 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 physician 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 Internal Medicine Consultants of York, Inc. has my permission to confirm my doctor's appointments on my answering machine or verbally to another household member.

I understand that Internal Medicine Consultants of York, Inc. 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 Internal Medicine Consultant, Inc. 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 anytime, you must contact our office in writing as soon as possible.

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: ______________________ Date of Birth: ______________ Age: __________

Gender (M/F):________ Today's Date(MM/DD/YY):__________ Health Care Provider:______________

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE BREAST CANCER*	*45*	—	—	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡$
- ☐ Three or more HBOC-associated cancers at any age‡$
- ☐ A previously identified HBOC syndrome mutation in the family

†*Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage*
‡*In the same individual or on the same side of the family*
$*HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer*

Lynch Syndrome - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

¶ *MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern*
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^*Cancer history should be on the same side of the family*

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:______________________________ Date: ____________

Health Care Provider's Signature: ______________________ Date: ____________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED
Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: