Internal Medicine Group

P.O. Box 7448 • Paducah, KY 42002-7448
www.internalmedicinegroup.com

It is a pleasure to welcome you to our office. Please complete both sides of this form to aid us in preparing or updating your clinical records. Of course, all information given to us will be strictly confidential. Please have your insurance cards available in order to make copies. This office will process your primary insurance and provide information to you for any additional insurances.

(Please Print)

DATE FORM COMPLETED:____________________ REFERRED TO THIS OFFICE BY: ____________________

___ Mr. ____ Ms. ____ Mrs. ____ Child ____
(Patient's full name, do not use initials or nicknames)

PATIENT'S ADDRESS:____
(Street and Number, City, State, Zip Code)

EMAIL ADDRESS: ____

SOCIAL SECURITY #: ____________________ PHONE: (Daytime)________________ (PM) ________________

____
(If patient is a minor, full name, address and phone number of responsible party)

PATIENT'S AGE:___________ PATIENT'S DATE OF BIRTH:____________________ MARITAL STATUS: ___________

PATIENT'S EMPLOYER: ______________________________ OCCUPATION: ____________________

EMPLOYER'S ADDRESS: ______________________________ EMPLOYER'S PHONE: ____________________

SPOUSE'S NAME:______________________________ SS #: ____________________ DOB:___________

SPOUSE'S EMPLOYER: ______________________________ OCCUPATION: ____________________

EMPLOYER'S ADDRESS: ______________________________ EMPLOYER'S PHONE: ____________________

INS. CO. (PRIMARY): ______________________________ POLICY #: ____________________

INS. CO. (SECONDARY):______________________________ POLICY #: ____________________

If your insurance is NOT Medicare or Kentucky Medicaid, please fill out the following insurance information.

PRIMARY CLAIM ADDRESS: ____

CITY:______________________________ STATE: ________________ ZIP:________________

NEAREST RELATIVE: ______________________________ PHONE NUMBER: ____________________
(Not living at patient's address)

RELATIONSHIP: ______________________________ ADDRESS: ______________________________

Is your visit to this office the result of an on the job injury? _____Yes _____No

Name of the person to contact and phone number to verify injury:______________________________

Have you been treated by any of our doctors previously? __________ Date last seen:____________________

Name of Pharmacy: ____________________ Address: ____________________ Phone #: ________________

Reason for this visit:____

____

I understand I am responsible for all charges that result from services rendered to me by the physician of **Internal Medicine Group**. I hereby authorize payment to be made directly to me or in the case of assignment to the **Internal Medicine Group** physician rendering services. I also authorize release of pertinent medical information to the insurance carrier.

______________________________ ______________________________
(Guarantor's Signature) (Date)

JP-008

Lake Printers, Inc.

Internal Medicine Group

Patient Name ______________________ Today's Date ______________

Date of Birth ______________________ Physician ______________

Reason for visit ____

____

____

____

List all current meds and dosages: ______________

List all medication allergies and reaction that occurs: ______________

List all chronic medical problems and surgeries: ______________

Family History (circle all that apply)

Mother: Living Deceased (age and cause of death) ______________

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other ______

Father: Living Deceased (age and cause of death) ______________

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other ______

Brothers (number of) ______ Sisters (number of) ______

Health problems in any siblings:

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other ______

Social History (circle reply)

Marital Status	S	M	W	D	Number of children ______
Cigarette Use	No	Yes	How much per day? ______		
Alcohol Use	No	Yes	How much per week? ______		
Employed	No	Yes	Type of work? ______		

Physician ______________________ Date ______________

Internal Medicine Group

Name ______________________________ Acct. # ______________

DOB ______________________________ Physician ______________

Review of Systems

Do you now or have you had chronic problems related to the following systems? Circle all that apply and explain on the back.

Constitutional Symptoms
Fever
Chills
Unexplained weight gain or loss
Excessive fatigue

Eyes
Blurred or double vision
Pain in eyes
Vision loss
Glaucoma or cataracts
Date of last eye exam ______________

Ears / Nose / Throat / Mouth
Recurrent ear infection
Chronic sore throat
Decreased hearing
Drainage from eyes or ears
Sores in mouth
Difficulty swallowing
Change in voice

Allergic / Immunologic
Environmental allergies
Chronic sinus congestion
Chronic runny nose

Respiratory
Wheezing
Frequent cough
Shortness of breath
Cough up blood

Cardiovascular
Palpitations
Chest pain / pressure
Decreased activity due to easy fatigue
Varicose veins
Pain in calf muscles with walking
Swelling of ankles

Gastrointestinal
Chronic diarrhea or constipation
Abdominal pain
Nausea / vomiting
Indigestion / heartburn
Jaundice
Hepatitis
Blood in stool or black stool
Change in bowel movements
Date of last colonoscopy ______________

Genitourinary
Blood in urine
Urine retention
Urinary frequency
Painful urination
Decrease in force of urine stream / dribbling
Urinary urgency / incontinence
History of sexually transmitted disease
FOR MEN ☐ Difficulty getting / retaining an erection
FOR WOMEN ☐ Vaginal discharge / dryness

Neurological
Headaches, frequent
Tremors
Dizzy spells
Numbness / tingling

Endocrine / Metabolic
Excessive thirst
Too hot / cold
Tired / sluggish
Date of last cholesterol test ______________

Integumentary
Skin rash
Boils
Persistent itch
New or change in moles

Musculoskeletal
Muscle pain or weakness
Joint pain / swelling / redness
Joint stiffness
Back / neck pain

Hematologic / Lymphatic
Persistent swollen glands
Blood clotting problems
Anemia
Blood transfusion
Date of last tetanus vaccine ______________
Date of last flu vaccine ______________
Date of last pneumococcal vaccine ______________

Lake Printers, Inc.

Psychologic

Are you generally satisfied with life? Yes or No
Do you feel sad most of the time? Yes or No
Change in appetite or sleep pattern? Yes or No
Decreased sexual desire? Yes or No
Irritable / moody? Yes or No
Crying spells? Yes or No
Nervous / anxious / difficulty concentrating? Yes or No

Female

Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain / Cramps Days of flow ______ Length of cycle ___________

Date - First day of last period ______________ ☐ Pain / bleeding during or after sex

Number of: Pregnancies ____ Abortions ____ Miscarriages ____ Live births ____

Birth control method ______________________________ Birth control pill (name) ____________________________

☐ Flushing / Menopause

Date of last PAP test ___________________________ ☐ Normal ☐ Abnormal

Date of last Mammogram __________________________ ☐ Normal ☐ Abnormal

Date of last Bone Density test _______________________ ☐ Normal ☐ Abnormal

Comments

Patient's Signature ____ Date ______________

Physician's Signature ______________________________________ Date ______________