Commonwealth Internal Medicine
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Date of Birth ___/___/___ Email Address:_____

NAME: (F, M, L) _____

Mailing Address: _____
Street/PO Box City State Zip

Physical Address: _____
Street City State Zip

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Employer Name: _____

Contact Preference: home cell work (Circle One) Male Female

Race:_____Ethnicity:_____Primary Language:_____

Marital Status: (Circle One) S, M, D, W Spouse Name: _____

Emergency Contact: _____

Relationship to Patient: _____ Home Phone #: _____

How did you hear of our practice? _____

Insurance Information

Primary Insurance Name: _____

Insurance Phone #: _____Name of Primary Policy Holder: _____

Last 4 SS# of Primary Policy Holder:_____DOB of Primary Policy Holder:_____

Group #: _____ Policy Identification #: _____

Secondary Insurance Name: _____

Insurance Phone #: _____ Policy Holder: _____

Group #: _____ Policy Identification #: _____

-OVER-

ASSIGNMENT AND RELEASE:

I authorize my insurance benefits to be paid to the Provider and acknowledge that I am financially responsible for any and all unpaid balances. I understand that Medical Insurance claims are billed by the provider, as a courtesy, if the provider participates in my insurance plan and if I promptly furnish the Provider with all correct insurance information. I further agree in the event of non-payment, to bear the cost of collection, court costs, and reasonable legal fees should this be required (18% interest per annum on all balances which are unpaid 60 days after services are rendered, attorney fees are stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court fees). In the absence of prompt payment, I further understand that medical, personal and financial records concerning these professional services will be released to the Provider's attorney for collection. The attorney will act as the Provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act". I also authorize the release of any medical information to my insurance carrier or any physicians following my medical care.

Patient Signature: _____ Date: _____/_____/_____

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Use and Disclosure of Protected Health Information

I understand that the commonwealth Internal Medicine may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at 540-371-4141.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

_____	_____	_____
Patient or Legal Surrogate	Date	Relationship to Patient

_____	_____
Witness	Date

****

I give Commonwealth Internal Medicine permission to leave medical information pertaining to my care on my home, cell, or work answering machine. I consent to receive automated calls and text messages.

Signature: _____ Date: _____

****

I give commonwealth Internal Medicine permission to speak to the following person(s) regarding my health care:

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

Commonwealth Internal Medicine

Patient Intake Sheet Todays Date: _____

Patient Name: _____ Date of Birth: _____

Are you interested in our patient portal?

If yes, please leave your email address: _____

Preferred Pharmacy: _____

1. Latest Flu Vaccine: _____
2. Latest Shingles Vaccine: _____
3. Latest Pneumococcal Vaccine: _____
4. Latest Tdap (Tetanus) Vaccine: _____
5. Latest Colon Cancer Screening (Colonoscopy or Cologuard): _____
6. Latest Mammogram: _____ Normal / Abnormal
7. Latest PAP: _____ Normal / Abnormal
8. Latest Eye Exam: _____
9. Latest Dental Exam: _____
10. Have you fallen 2 or more times in the past year? Y / N
11. Do you currently use any type of tobacco? Y / N
12. Do you ever miss taking any of your prescribed medications? Y / N
13. Can you afford all of your prescribed medications? Y / N
14. Do you have any of the following?: Living Will / Medical Power of Attorney / Advance Directive / No
15. Over the past 2 weeks how often have you felt or been bothered by:
    (**Circle** the Number that corresponds. Please answer both questions.)

A. Little interest or pleasure in doing things?	B. Feeling down, depressed or hopeless?	
0	0	Not at All
1	1	Several Days
2	2	More Than Half The Days
3	3	Nearly Every Day

16. Medicare Patient: Are you up to date on you Annual Wellness Visit? Y / N
    *Medicare provides this covered physical benefit yearly
    **This can be done along with your next follow up appointment.

STOP - Below questions are for office staff. Thank you.

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For Provider and Nurse To Complete:

17. Latest BMP or CMP: _____
18. Latest HbA1c: _____
19. Latest Urine/Protein Screening: _____
20. If patient is a tobacco user, were they advised to quit? Y / N
21. Todays BP Reading: _____
22. 2nd BP Reading (If initial was over 139/89): _____

Patient Name (please print): _____

FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____
Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY

_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Chickenpox Date: _____
- ☐ Flu Shot Date: _____
- ☐ Gardasil/HPV Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Meningococcus Date: _____
- ☐ MMR (*Measles, Mumps, Rubella)* Date: _____
- ☐ Pneumonia Date: _____
- ☐ Tdap (*Tetanus and pertussis)* Date: _____
- ☐ Tetanus Date: _____
- ☐ Zostavax (*Shingles)* Date: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
☐ Cesarean sections If yes, then number: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
  - Current sexual partner is ☐ Female ☐ Male
  - Do you use condoms? ☐ Yes ☐ No
  - Other Birth control method used: _____
  - ☐ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
2.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Occupation

_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level
- ☐ None (No exercise)
- ☐ Occasional exercise
- ☐ Moderate exercise
- ☐ High level exercise

Caffeine
☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? _____

Alcohol
Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week
How many drinks per week? __

Tobacco
Do you use tobacco?
☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
- ☐ Cigarettes - _____pks./day
- ☐ Chew - _____/day
- ☐ Cigars - _____/day
- ☐ # of years_____

Or year quit _____

Drugs
Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:

_____

_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

Patient, Guardian, or Care Giver Signature:_____

Date:_____