

NORTH SHORE INTERNAL MEDICINE, P.C.

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Patient Registration Form

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Date of Birth: _____

Social Security #: _____ Marital Status: _____ Spouse's Name: _____

Mother/Father's Name: _____

In Emergency, Notify: _____ Phone: _____

Referred By: _____

City: _____ State: _____ Zip: _____

Does patient have Medicare? Yes No Primary Secondary

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to policy holder: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to policy holder: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Tertiary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to policy holder: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO **NORTH SHORE INTERNAL MEDICINE ASSOCIATES, P.C.** FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED: _____ DATE: _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO **NORTH SHORE INTERNAL MEDICINE ASSOCIATES, P.C.** FOR SERVICE(S) DESCRIBED.

SIGNED: _____ DATE: _____

**NORTH SHORE INTERNAL MEDICINE
PATIENT HISTORY FORM**

NAME: _____

DATE: _____

Please complete the following information to assist us in your care:

SURGICAL HISTORY

Type of Operation	Year	Surgeon	Hospital

HOSPITALIZATIONS FOR MEDICAL ILLNESSES

Illness	Year	Physician	Hospital

MEDICATION ALLERGIES AND SENSITIVITIES

Medication	Reaction

MEDICATIONS CURRENTLY TAKING

Medication	Dosage	Frequency

PLEASE CONTINUE ON FOLLOWING PAGE

Please check those conditions on the following list which you have had:

- | | |
|---|--|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Cancer Site _____ |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Lyme disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Typhoid fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Depression |

FAMILY HISTORY

Please check any of the conditions below which have occurred in any blood relations; indicate which relation was affected:

- | | |
|--|---|
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Blood disease _____ |
| <input type="checkbox"/> Genetic disease _____ | <input type="checkbox"/> Alcoholism _____ |

PERSONAL HISTORY

- Did you have any significant childhood illnesses? _____
- Do you smoke? No Yes How much daily? _____
- If you previously smoked, when did you quit? _____
- How much alcohol do you drink in a week? _____
- Do you follow a particular type of diet? _____
- How much coffee or tea do you drink daily? _____
- How much regular exercise do you get? _____
- How many hours do you sleep each night? _____ Poorly Well
- If you have gained or lost weight in the past 6-12 months, how much? _____
- Where have you lived? _____
- Recent travel to tropical countries? _____
- Would you describe yourself as tense, nervous, stressed?

PLEASE CONTINUE ON FOLLOWING PAGE.

SYSTEMS REVIEW

Please check any of the following which you have experienced:

- Frequent or severe headaches.
- Being knocked unconscious.
- Swelling or lumps in your neck.

- Need for eye glasses or contact lenses.
- Double vision.
- Other eye problems. Specify _____
- Difficulty hearing.
- Frequent or constant ringing in your ears.
- Frequent or severe nosebleeds.
- Significant allergies or hay fever.
- Sinus problems.
- Difficulty with mouth or throat. Specify _____

- Chronic cough.
- Bringing up more than a teaspoon of phlegm per day.
- Coughing up blood.
- Hearing a wheeze or whistle in your chest.
- Pulmonary embolus (blood clot traveling to the lungs).
- Pain on taking a deep breath.
- Have you had a chest X-ray? Most recent date _____

- Hypertension (high blood pressure).
- Heart attack.
- Palpitations (sensation of heart beating rapidly or irregularly)
- Tightness, pressure, or pain in the chest.
- Shortness of breath with exertion (for instance, climbing stairs).
- Awakening at night short of breath.
- Using more pillows to help you breathe at night.
- Swelling of ankles or lower legs.
- Heart murmur or problems with heart valves.
- Mitral valve prolapse ("floppy" valve).
- Leg cramps when walking.

- Frequent or severe heartburn.
- Difficulty swallowing or feeling that food is sticking on the way down.
- Excessive belching. Flatulence.
- History of an ulcer. Gastritis.
- Vomiting blood.
- Gallstones or gall bladder attacks.
- Hepatitis or other liver problems. Specify _____
- Jaundice (yellow eyes and/or skin).
- Black, tarry stools. Bright red blood in the stools.
- Long periods of diarrhea, constipation.
- Irritable bowel or spastic colon.
- Change in usual bowel habits.
- Frequent pencil-thin stools.
- Colon or rectal polyps. Hemorrhoids.
- Stomach or bowel X-rays. Colonoscopy or endoscopy. Date _____

PLEASE CONTINUE ON FOLLOWING PAGE.

- Frequent urination during the day, evening.
- Pain or burning when you pass your urine.
- Dark or bloody urine.
- Constant feeling of an urge to urinate.
- Difficulty starting your urine flow.
- Difficulty with sexual function.

MEN:

- Weak or slow urinary stream.
- History of prostate problems.
- Burning or discharge from the penis.
- Swelling or lumps in the testicles or painful testicles.

WOMEN:

- No longer get periods. Hysterectomy. Date of last menstrual period ___/___/___
Date of most recent Pap smear ___/___/___
- Vaginal bleeding after menopause.
- Irregular menstrual periods.
- Heavy bleeding with periods.
- Recent vaginal itch or discharge.
- Lumps or pain in the breasts. Date of most recent mammogram ___/___/___
Number of pregnancies ____. Children born alive ____. Miscarriages ____.
- History of an abortion.

MEN AND WOMEN:

- Aching muscles or joints.
- Swollen joints.
- Chronic back problems.
- History of hernia.
- Phlebitis (blood clot in the legs.)

- Fainting or feeling faint.
- Seizure or convulsions.
- Loss of feeling in any part of the body.
- Vertigo (sensation that your are spinning around or that the room is spinning).

- Anemia (low blood count or low iron).
- Excessive bleeding when cut or with dental work. Easy bruising.
- Other blood disorder. Specify _____

- Excessive thirst.
- Recent intolerance of hot weather, cold weather.
- Excessive fatigue.

- Skin problems. Specify _____

- Psychiatric or psychological care.
- Feeling sad or depressed. Feeling anxious or worried.
- History of drug or alcohol abuse.
- Under a lot of stress.