# Internal Medicine Associate

Dr. Rakesh Prasad  Dr. Sujata Prasad  Kaylee Terrell, APRN-CNP  Garrett Morgan, NP

## New Patient Packet

| First Name | Last Name | MI | Date of Birth | Age |
|---|---|---|---|---|
| | | | | |

| Home Address | City | ZIP |
|---|---|---|
| | | |

| Phone: | Social Security # | E-Mail: |
|---|---|---|
| | | |

| Relationship | Gender at birth | Gender | Sexual Orientation |
|---|---|---|---|
| ☐ Single<br>☐ Married<br>☐ Divorced<br>☐ Widowed<br>☐ Life Partner | ☐ Male<br>☐ Female | ☐ Male<br>☐ Male to female<br>☐ Female<br>☐ Female to male<br>☐ Other_____ | ☐ Straight<br>☐ Lesbian<br>☐ Gay<br>☐ Bisexual<br>☐ Other _____ |

| Ethnicity | Race | | | Number of Children: |
|---|---|---|---|---|
| ☐ Hispanic<br>☐ Non-Hispanic<br>☐ Unknown | ☐ Alaskan Native<br>☐ American Indian<br>☐ Asian | ☐ African American<br>☐ Hawaiian Native<br>☐ Middle Eastern | ☐ White<br>☐ Declined<br>☐ Unknown | |

## Emergency Contact Details

| Name: | Relationship to you: | Phone: |
|---|---|---|
| | | |

## Preferred Pharmacy

| Name: | Address: | Phone: |
|---|---|---|
| | | |

## Allergies

☐ No Known Allergies

| | | |
|---|---|---|
| | | |

## Immunizations

| | | | |
|---|---|---|---|
| □ Influenza | Date: | □ Tetanus | Date: |
| □ Pneumonia 13 | Date: | □ Shingrix | Date: |
| □ Pneumovax 23 | Date: | □ Other: | Date: |

| Smoking History | Alcohol |
|---|---|
| ☐ Never | ☐ Non Drinker |
| ☐ Former smoker – Date quit: / / | ☐ Rarely/Light |
| ☐ Current smoker - Packs/day: | ☐ Moderate |
| ☐ Number of years smoking | ☐ Heavy |

List types of alcohol drunk:

**Please list any other recreational drug use**. Ex: marijuana, cocaine, ecstasy etc.

| Name of Drug | Date last used |
|---|---|
| | |
| | |
| | |

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### Your Health History

Please list your current and regular medications including prescription, over the counter medications, vitamins and herbal medicine below:

☐ I do not take any medications

| Name | Mg/day | Reason Prescribed or taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Preventative screening

| | | | | | |
|---|---|---|---|---|---|
| Mammogram | Date: | EKG | Date: | Eye Exam | Date: |
| Pap Smear | Date: | Echocardiogram | Date: | Foot Exam | Date: |
| Prostate Exam | Date: | Cardiac Stress Test | Date: | Spirometry | Date: |
| Colonoscopy/FOBT | Date: | Bone Density | Date: | Physical | Date: |

### PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

_____

_____

_____

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## FAMILY HISTORY

Please note if either you or any of your family have ever suffered from any significant medical problem please. If possible, note the age of onset of cardiac events and type of cancer, arthritis or allergy. Otherwise simply tick.

| | Self | Father | Paternal Grand Father | Pat. Grand Mother | Mother | Maternal Grand Father | Maternal Grand Mother | Your Siblings | Your children |
|---|---|---|---|---|---|---|---|---|---|
| **Alcoholism** | | | | | | | | | |
| **Allergies** | | | | | | | | | |
| **Anxiety** | | | | | | | | | |
| **Asthma** | | | | | | | | | |
| **Arthritis** | | | | | | | | | |
| **Bowel Disease** | | | | | | | | | |
| **Cancer** | | | | | | | | | |
| **Dementia** | | | | | | | | | |
| **Depression** | | | | | | | | | |
| **Diabetes** | | | | | | | | | |
| **Epilepsy** | | | | | | | | | |
| **Gall Stones** | | | | | | | | | |
| **Heart Attack** | | | | | | | | | |
| **Hypertension** | | | | | | | | | |
| **Osteoporosis** | | | | | | | | | |
| **Parkinson's** | | | | | | | | | |
| **Schizophrenia** | | | | | | | | | |
| **Stroke/TIA** | | | | | | | | | |
| **Thyroid disease** | | | | | | | | | |
| **Other** | | | | | | | | | |

## SYSTEMS REVIEW

**In the past month, have you had any of the following problems?**

**GENERAL**
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

**MUSCLE/JOINTS/BONES**
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

**EARS**
- ❑ Ringing in ears
- ❑ Loss of hearing

**EYES**
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

**THROAT**
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

**HEART AND LUNGS**
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

**NERVOUS SYSTEM**
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

**STOMACH AND INTESTINES**
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

**SKIN**
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

**BLOOD**
- ❑ Anemia
- ❑ Clots

**KIDNEY/URINE/BLADDER**
- ❑ Frequent or painful urination
- ❑ Blood in urine

**Women Only:**
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

**PSYCHIATRIC**
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

**OTHER PROBLEMS:**

**WOMENS REPRODUCTIVE HISTORY:**
Age of first period:
# Pregnancies:
# Miscarriages:
# Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family?
YES NO

If YES, please name the members allowed:

| Name | Phone | Relationship to you |
|---|---|---|
| | | |
| | | |
| | | |

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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# MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me. By releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/facility/entity/person listed below.

Patient name:_____DOB:_____

The information you may release subject to this signed release form is as follows:

| | | |
|---|---|---|
| __ COMPLETE RECORDS<br>__CARE PLAN<br>__PATHOLOGY<br>__HOSPITAL RECORDS | __HISTORY & PHYSICAL<br>__LAB REPORTS<br>__TREATMENT RECORD<br>__MEDICATION RECORDS | __PROGRESS NOTES<br>__RADIOLOGY REPORTS<br>__OPERATIVE REPORTS<br>__OTHER (PLEASE SPECIFY) |

I would like to Release my protected health information from the following physician/facility/person and/or those who are directly associated with my medical care:

_____

_____

_____

_____

Date: _____

Printed name: _____ DOB:_____

Signature of patient or personal representative: _____

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# No-show for appointments and cancellation of appointments on the day of service

Recently, no-shows and cancellations for appointments on the day of service have become a problem. This is making scheduling very difficult. In the past, we have charged $25 penalty, but in recent years have not enforced it.

We are now going to enforce the $25 penalty for no-show or cancellation of appointments within 24 hours of the appointment. **This would need to be paid before a future appointment.**

Habitual "no-show for appointment" are now going to be dropped from our practice. We will continue to see patients who are keeping their appointments. We will also continue to provide same-day appointments if available, and even see new patients on same day as they call, if possible.

We hope by doing this that we can improve accessibility for patients that need to be seen. We hope that you understand.

Sincerely,

Dr. Rakesh and Sujata Prasad
Nurse Practitioner, Garrett Morgan

Patient signature: _____ Date: _____