Internal Medicine Associates

Dr. Rakesh Prasad, MD Kaylee Terrell, APRN-CNP

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 ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner	☐ Male ☐ Female	☐ Male ☐ Male to female ☐ Female ☐ Female to male ☐ Other_____	☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Other _____

Ethnicity	Race		
☐ Hispanic ☐ Non-Hispanic ☐ Unknown	☐ Alaskan Native ☐ American Indian ☐ Asian	☐ African American ☐ Hawaiian Native ☐ Middle Eastern	☐ White ☐ Declined ☐ 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.

	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									

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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

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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	__HISTORY & PHYSICAL	__PROGRESS NOTES
__CARE PLAN	__LAB REPORTS	__RADIOLOGY REPORTS
__PATHOLOGY	__TREATMENT RECORD	__OPERATIVE REPORTS
__HOSPITAL RECORDS	__MEDICATION RECORDS	__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 a $25 penalty, but in recent years have not enforced it.

We are now going to enforce the $35 penalty for follow up and $50 penalty for Wellness no-show/ cancellation of appointments within 24 hours of the appointment. **This would need to be paid for 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 Prasad

Kaylee Terrell, APRN-CNP

Patient signature: _____ Date: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓ "to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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