Bellingham Internal Medicine

New Patient Registration Form

Name:____

Address:____ Apt # ____________

City________________________________ State__________ Zip Code _________

Date of Birth: _________________________ Marital Status M W D O

Home Phone :_________________________ Work Phone:__________________________

Cell phone:___________________________ Fax:_________________________________

Preferred Contact: ☐ Home ☐ Work ☐ Cell

E-mail Address:____

Social Security No. ____

Referred by: ____________________________

Employed by: ___________________________ Occupation: _________________________

Primary Insurance Company ____

Primary Insurance ID No____

Secondary Insurance Company____

Secondary Insurance ID No____

Emergency Contact: ____________________________________ Phone #_________________

Referred by ____

Preferred Pharmacy (if any)____

By signing below, I authorize the Bellingham Internal Medicine Associates or its agents to furnish to any hospital, health care service plan, or insurer any medical information obtained if such disclosure is necessary to allow the processing of any insurance claims. I have been given the opportunity to examine the "Notice of Privacy Practice" and "Notice of Patients Rights" if I so desire. I acknowledge that I am financially responsible for any co-payments, deductibles or denials of payment by my insurance company and authorize the charging of any co-pay or insurance mandated deductible due to my credit card on file at the office.

Signature: ____________________________________ Date ____________________

Bellingham Primary Care

Bellingham Internal Medicine Associates, P.C.

____
Name

AGE: _______ How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

PRESENT HEALTH CONCERNS: ____

____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose (eg. mg/pill)	How many times per day	When started

ALLERGIES or REACTIONS TO MEDICINES: ____

When were your most recent **IMMUNIZATIONS:**

Hepatitis A ____ Hepatitis B ____ Influenza (Flu Shot) ____ Measles ____ Pneumovax (Pneumonia) ____

Rubella ______ Tetanus (Td) ___ Varicella (chicken pox) shot _____ or Illness ____

When were your most recent **HEALTH MAINTENANCE** screening tests:

Lipid (Cholesterol Screening) ____ Results? ___________

Mammogram ____ Results? ____________________

Ever abnormal? ____ Details: __________________

Pap Smear ____ Results? ______________________

Ever abnormal? ____ Details: __________________

PSA (Prostate cancer screen) ____ Results? _______

Stool test for blood ____ Results? _______________

Sigmoidoscopy? _____ Results? ________________

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

___ Heart disease:
specify type _________________

___ Heart attack (412)

___ High blood pressure (401.9)

___ Diabetes (Endo, 250.00)

___ High cholesterol (Endo, 272.4)

___ Thyroid problem (246.9)
specify type _________________

___ Bleeding/clotting problem (286.9)

___ Blood transfusion (V58.2)

___ Cancer (Malignancy)
specify type _________________

___ Stroke

___ Depression/suicide attempt (311)

___ Alcoholism (Sub, 303.90)

Other problems (specify):

____

____

____

SURGICAL HISTORY:

Please list all prior operations (with dates): ______________________________

____

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August 1999

SOCIAL HISTORY

Substance & Sexuality

Tobacco Use

Cigarettes ❑ Never ❑ Quit: Date ________________
❑ Current: Smoker: packs/day ______ # of yrs _______

Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew
Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes: # drinks/week _____
Is alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes
Have you ever used needles? ❑ No ❑ Yes

Sexual Activity

Sexually Active: ❑ Yes ❑ No ❑ Not currently
Current sex partner(s) is/are: ❑ male ❑ female

Birth control method: ________________ ❑ None needed
Have you ever had any sexually transmitted diseases (STDs)? ❑ No ❑ Yes
Are you interested in being screened for sexually transmitted diseases? ❑ No ❑ Yes

Other Concerns

CAFFEINE Intake: ❑ None ❑ Coffee/tea: _____ cups/day
❑ Sodas: _____ /day ❑ Chocolate: _____ oz./day

WEIGHT: Are you satisfied with your weight? ❑ No ❑ Yes

DIET: How do you rate your diet? ❑ Good ❑ Fair ❑ Poor

Do you take SUPPLEMENTS? ______________________

Do you drink 4 lg. glasses of milk daily or take CALCIUM supplements? ❑ No ❑ Yes

EXERCISE: Do you exercise regularly? ❑ No ❑ Yes

What kind of exercise? ______________________

How long (minutes) _____ How often? _______________

If you do not exercise, why? ______________________

BIKE HELMET: Do you use a bike helmet? ❑ No ❑ Yes

SEAT BELT: Do you use seatbelts consistently? ❑ No ❑ Yes

Is VIOLENCE at home a concern for you? ❑ No ❑ Yes

Have you ever been ABUSED? ❑ No ❑ Yes

Do you have a GUN in your home? ❑ No ❑ Yes

Socioeconomics

Occupation: ____________________________ Employer ______________________________

Years of Education/Highest Degree ____________ Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other: ________________

Spouse/Partner's name: ____________________________ Number of children/ages: ____________________

Who lives at home with you? ____

SPECIALTY HISTORY:

For women: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: ____

1st day, most recent period: _______ Age at 1st period: ______ Frequency of periods: _______ Length of each: ______

Do you have any concerns about your periods? ❑ No ❑ Yes: ____

Do you have any concerns about menopause? ❑ No ❑ Yes: ____

REVIEW OF SYMPTOMS:

Please check (✓) any current problems you have on the list below:

Constitutional
___ Fevers/chills/sweats
___ Unexplained weight loss/gain
___ Change in energy/weakness
___ Excessive thirst or urination

Eyes
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficult hearing/ringing in ears
___ Problems with teeth/gums
___ Hay fever/allergies

Cardiovascular
___ Chest pain/discomfort
___ Palpitations

Chest (breast)
___ Breast lump/nipple discharge

Respiratory
___ Cough/wheeze
___ Difficulty breathing

Gastrointestinal
___ Abdominal pain
___ Blood in bowel movement
___ Nausea/vomiting/diarrhea

Genitourinary
___ Nighttime urination
___ Leaking urine
___ Unusual vaginal bleeding
___ Discharge: penis or vagina

Musculo-skeletal
___ Muscle/joint pain

Skin
___ Rash/mole change

Neurological
___ Headaches
___ Dizziness/light-headedness
___ Numbness
___ Memory loss
___ Loss of coordination

Psychiatric
___ Anxiety/stress
___ Problems with sleep
___ Depression

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Other
___ Problems with sexual function

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FAMILY HISTORY:

Please indicate the current status of your immediate family members:

		Alive	Deceased	Age (now or at death)	Comments/Cause of death
Mother:		______	______	______	______________________
Father:		______	______	______	______________________
Sister(s):	# ______	______	______	______	______________________
Brother(s):	# ______	______	______	______	______________________
Daughter(s):	# ______	______	______	______	______________________
Sons(s):	# ______	______	______	______	______________________