Integra Health MD

PATIENT MEDICAL INFORMATION

DATE: _____/_____/_____

Patient Name: _____ DOB: _____ Age: _____

Reason for your visit today: _____

Allergies: _____

Have you been treated by a physician in the past 2 years? _____ Yes _____ No

If so, conditions(s) are being treated for: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT MIGHT APPLY TO YOU:

_____ High Blood Pressure
_____ Prior heart attack
_____ Heart failure
_____ Chronic lung disease
_____ Diabetes ___ Pills___ Insulin
_____ Unintended weight loss
_____ Unintended weight gain
_____ Fatigue
_____ Fever/ Chills
_____ Sweats
_____ Intolerance of heat
_____ Insomnia
_____ Loss of vision
_____ Cataracts
_____ Cataract Surgery
_____ Glaucoma
_____ Intolerance at bright light
_____ High Cholesterol
_____ High lipids
_____ Angina/Chest pain
_____ Bypass surgery
_____ Angioplasty
_____ Irregular Breast
_____ Palpitations
_____ Poor Circulations
_____ Emphysema
_____ Asthma
_____ Sleep Apnea
_____ Short of Breath

_____ Chronic cough
_____ Hoarseness
_____ Ulcers
_____ Acis reflux
_____ GERD
_____ Persistent heartburn
_____ Nausea
_____ Vomiting
_____ Constipation
_____ Diarrhea
_____ Blood in stool
_____ Abdominal pain
_____ Difficulty swallowing
_____ Hepatitis
_____ Kidney stones
_____ Kidney failure
_____ Dialysis
_____ Burning w/urination
_____ Blood in urine
_____ Past infections
_____ Arthritis
_____ Replacements
_____ Gout
_____ Osteoporosis
_____ Biopsies
_____ Lump
_____ Abnormal Mammogram
_____ Breast pain

_____ Bleeding/discharge
_____ Pelvic pain
_____ Skin cancer
_____ Moles
_____ Eczema
_____ Epilepsy
_____ Seizures
_____ Fainting
_____ Stroke (Date_____)
_____ Headaches
_____ Numbness
_____ Tingling
_____ Dizziness
_____ Depression
_____ Anxiety
_____ Feeling of despair
_____ Panic attacks
_____ Mental Illnesses
_____ Overactive thyroid
_____ Underactive thyroid
_____ Mass
_____ Blood clots
_____ Varicose veins
_____ DTV
_____ Anemia
_____ Bruising

Cancer survivor, Details please: _____

Date of last: Colonoscopy _____ PSA _____ MAMMO _____

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Family History:

Father _____ Alive _____ Deceased. Medical Problems: _____

Mother _____ Alive _____ Deceased. Medical Problems: _____

Bothers _____ Alive _____ Deceased. Medical Problems: _____

Does anyone in your immediate family suffer from (circle):

Heart disease, High blood pressure, cancer, Diabetes.

Do you: Smoke _____ Drink _____ Use recreational drugs _____

Any artificial openings? Yes_____ No _____ Where: _____

Any amputations? Yes _____ No _____ Where: _____

Date of your last Eye exam: _____ Glaucoma Test: _____

Have you ever had a myocardial infarction? Yes _____ No _____ Date: _____

Are you in any pain: Yes _____ No _____ Since when: _____

On a scale 1-10, what is your pain level? _____ Describe: _____

Advance care planning: (circle preference) 1. DNR 2. Full resuscitation 3. No intubation

Do you have a Living Will: Yes _____ No _____ Power of attorney: Yes _____ No _____

Situational Review – Functional Assessment:

1. **Describe your current living arrangement:**

_____ Home/apartment/ condominium __ _____ Senior/Low income/ Subsidized housing

_____ Assisted Living Facility _____ Other _____

2. **With whom do you currently live?**
   ___ Alone ____ Spouse ____ Children ____ Other Family Member ___ Other _____
3. **Do you require assistance to leave your residence?** Yes _____ No _____
4. **Do you currently have difficulties with everyday tasks/Activities (select all that apply):**

_____ Bathing	_____ Dressing	_____ Toileting/Incontinency
_____ Preparing Meals	____ Laundry/Housekeeping	_____ Transportation
_____ Running Errands	____ Getting around the house	_____ Function Independency

5. **Do you have to choose each month between paying for food, medication, utilities or other necessities?** Yes _____ No _____

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6. **Do you require assistance with communications?** Yes _____ No _____ Explain: _____

7. **Do you require the usage of Durable Equipment on a daily basis?** Yes _____ No _____

   Select all that apply:
   ____ Oxygen ____ Wheelchair ____ Cane _____ Walker _____Electric Scooter
   Other _____

Medications: (List all the prescriptions and OTC Medications with dosages)
_____
_____

Does the patient have any barrier to taking medications as prescribed? _____

Physician reconciled medications today? Yes _____ No _____

Past Medical and Surgical History:

_____

_____

PRINT YOUR NAME:

Patient Name: _____ **DOB** _____

Signature (Patient/Legal Guardian):_____**Date:** _____