

Associated Internal Medicine Medical Group, Inc., 350 30th Street, Suite 320, Oakland, California 94609
510-465-6700 Voice, 510-465-7765 Fax

Date form completed _____

Last Name _____ First Name _____ Middle Initial _____

Prefix: Mr. Mrs. Ms Miss Dr. email address _____

Home address _____

Home phone _____ Cell Phone _____

Work Phone _____ Which phone # should we use first to reach you? Home Cell Work

Soc Sec # _____ Date of Birth _____ Gender M F

Marital Status _____ Occupation _____

Employed by _____ Retired? Yes No

Primary Insurance _____ ID # _____

If HMO, what is the doctor's name on your card? _____

If HMO, which medical group (circle) Hill Physicians Med Grp---Alta Bates Med Grp---Other Med Grp

Second Insurance if applicable _____ ID# _____

Who referred you to this office? _____

Preferred pharmacy & address _____

Preferred mail order pharmacy & fax # _____

Contact person _____ Phone number _____

Relationship _____ If spouse, employer _____

I request that payment of insurance benefits be made on my behalf to Associated Internal Medicine Medical Group Inc., or an individual provider in the group, or any services furnished me by that provider. I authorize any holder of medical information about me to release to the insurance carrier and its agents information needed to determine these benefits. **I understand I am financially responsible for any deductible, coinsurance, copay, and noncovered services.** This remains in effect until revoked by me in writing. I authorize Associated Internal Medicine Medical Group Inc., to use my Protected Health information for treatment, payment, and business operations. **NOTICE TO CONSUMERS:** Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.

Signature _____

Date _____

Name _____ Date _____

CURRENT MEDICAL PROBLEMS. Please list in order of importance to you.

_____ How long _____
_____ How long _____
_____ How long _____
_____ How long _____

PAST MEDICAL HISTORY

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cerebrovascular accident | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Atrial Fib | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine headaches | Other: _____ |

PAST SURGICAL HISTORY-please write in year

- | | | |
|---|--|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Hip replacement | For Females: |
| <input type="checkbox"/> Angio w/stent | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Augmentation mammoplasty |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> LASIK | <input type="checkbox"/> Bilat tubal ligation |
| <input type="checkbox"/> Arthroscopy knee | <input type="checkbox"/> Liver biopsy | <input type="checkbox"/> Breast biopsy |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> Open reduct internal fixation | <input type="checkbox"/> Cesarean section |
| <input type="checkbox"/> Coronary artery bypass graft | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> D and C |
| <input type="checkbox"/> Carpal tunnel release | <input type="checkbox"/> Small bowel resection | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Cataract extraction | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Mastectomoy |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Myomectomy |
| <input type="checkbox"/> Colectomy | For Males: | <input type="checkbox"/> Reduction Mammoplasty |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Prostate biopsy | <input type="checkbox"/> Total abd hysterectomy/BSO |
| <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> TURP | <input type="checkbox"/> Vaginal hysterectomy |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Vasectomy | Other: _____ |

Physicians you have seen in the past three years and why:

Name _____ Date _____

MEMBER	AGE	ILLNESSES IF ANY	IF DECEASED, AT WHAT AGE	CAUSE OF DEATH
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				
Spouse				
Son				
Son				
Son				
Daughter				
Daughter				
Daughter				

SOCIAL HISTORY

Birthplace _____ How long in California _____

Education--last year of school completed _____

Do you use tobacco? Y N former (year quit _____) Type _____

Ever tried to quit? Y N # of years of tobacco use _____

Packs per day _____ Second hand smoke exposure? Y N

Do you drink alcoholic beverages? Y N If no, did you previously drink regularly? Y N

Do you drink caffeine beverages? Y N Coffee _____ Tea _____ Sodas _____

Do you Exercise? Y N Type _____ Frequency _____ Duration _____

Hobbies and activities _____

Do you use a seat belt when driving and when a passenger? Y N

Would you allow a blood transfusion if your physician considered it necessary? Y N

Do you have an Advance Directive in Place? Y N

To whom can we talk to about your medical care? _____

In the case of a medical emergency? _____ Phone # _____

At what number can we leave you a confidential voice mail message? _____

Name _____ Date _____

Please list all **current medications** (prescription, over the counter, herbal, recreational). Give dosage and frequency.

_____	_____
_____	_____
_____	_____
_____	_____

List any medication allergies or adverse reactions:

Immunizations Do you know if and when you had these immunizations?

Hepatitis A _____	Polio injection or oral _____
Hepatitis B _____	Tetanus _____
HPV (Gardasil) _____	Typhoid _____
Influenza _____	Varicella _____
Measles, Mumps, Rubella _____	Yellow Fever _____
Meningitis _____	Zoster (Shingles) _____
Pneumonia _____	

PLEASE CIRCLE PROBLEMS YOU HAVE, IF ANY:

- | | |
|------------------------|--|
| Allergies, immunity | environmental allergies, food allergies |
| Cardiovascular: | chest pain, calf pain when walking, irregular heartbeat, palpitations |
| Constitutional: | fatigue, fever, night sweats |
| Endocrine: | cold intolerance, heat intolerance, excessive thirst, excessive eating |
| Ear,nose,mouth,throat: | ear drainage, hearing loss, nasal drainage |
| Eyes: | eye discharge, vision loss |
| GI track: | abdominal pain, constipation, diarrhea, vomiting |
| Genital,Urinary: | painful urination, blood in urine, penile discharge, excessive urination |
| Blood, lymph: | bleeding, easy bruising |
| Skin,hair,nails: | Itching, rash |
| Muscles, bone: | bone symptoms, joint pain, muscle weakness |
| Neurological: | gait disturbance |
| Mental: | psychiatric symptoms |
| Respiratory: | cough, shortness of breath, wheezing |