INTERNAL MEDICINE DIAGNOSTICS

197 Hospital Dr., Suite # B
Cherokee Village., AR 72529
Phone: 870-257-5118 Fax: 870-257-6215

Welcome to our office. Your efforts to fill this form are really appreciated.

Patient Name Last First M.I.				Social Security #:	Date of visit
Birth Date	Age	Gender: ☐ Male ☐ Female ☐ Transgender	Language: ☐ English, ☐ Spanish, ☐ Other, ☐ Refuse to Report	Marital Status: ☐ Married, ☐ Divorced, ☐ Widowed, ☐ Separated, ☐ Single, ☐ Life Partner	

Street Address	City, State & Zip Code	Cell Ph #	Home Ph #
Patient's or Parent's or Spouse Employer	Occupation (Indicate if Student)	Employed for Y___M___D__	Bus. Ph #
Employer Street Address	City and State	Zip Code	Ph #
Spouse or Parent's Name or Emergency Contact Person Name			
Street Address	City and State	Zip Code	Ph #
Previous Family Physician Name	Street Address	City, State, Zip	Ph #
Referred by	Street Address	City, State, Zip	Ph#
	Street Address, City, State	Zip Code	Home Phone
Email Address			

Race : ☐ White, ☐ Hispanic, ☐ African-American, ☐ Native American, ☐ Asian, ☐ Native Hawaiian/Pacific Islander, ☐ Other, ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino, ☐ Non-Hispanic or Latino, ☐ Refuse to Report

Drug and Other Allergies:

Present Medications (including over the counter medications):		**Past Medications:-**
1	2	A
3	4	B
5	6	C
7	8	D
9	10	E

Pharmacy: **Local:** **Mail Order:**

INTERNAL MEDICINE DIAGNOSTICS

Present Complaint:				
Past Medical History:-				
Chicken pox	Mump	Measles	Rubella	Bone Disease
Emphysema	Asthma	Tuberculosis	Diabetes	Hypertension
Heart trouble	Kidney disease	Liver disease	Stroke	Parkinson's
Skin cancer	Lung cancer	Colon cancer	Other cancer	Joint problems
Past Surgical History: 1.			2.	
3.			4.	
Travel outside USA				

OBG History:- G_____P_____A_____SB_____LC_____Twins_____			
Last period	Frequency	Regularity	Duration of flow
Contraception type	Are you pregnant now	Breastfeeding	
Genital Herpes / Ulcers	Syphilis	Gonorrhea	
Last mammogram	Last Breast Exam	Last PAP Smear	
Menopause symptoms	Circumcision	Vasectomy	

Family History:-				
Children (How many)	Living	Deceased	Disease	
Sisters **(**How many)	Living	Deceased	Disease	
Brothers (How many)	Living	Deceased	Disease	
Mother	Living	Deceased	Disease	
Father	Living	Deceased	Disease	
Grand Mother	Living	Deceased	Disease	
Grand Father	Living	Deceased	Disease	
Diabetes	Hypertension	Heart disease	Obesity	High Cholesterol
Gall Stones	Arthritis	Liver disease	Kidney disease	Bleeding disease
Cervical Cancer	Uterine cancer	Breast cancer	Lung cancer	Colon cancer

Social history:-			
Tobacco use	How many packs/day	Years	Quit in
Alcohol use	How much/kind/day	Years	Quit in
IVDrug abuse	How much/kind/day	Years	Quit in
Education		Occupation	

Review of Systems:-				
Weight (loss or gain)	Headaches	Dizziness	Eye problems	Ear problems
Nose problems	Sore throat	Chest pain	Palpitation	Wheezing
Short of Breath	Cough	N/V/D/C	Dysuria	Frequency
Urgency	Retention	Incontinence	Reflux symptoms	Abdominal pain
Loss of consciousness	Seizures	Photosensitivity		

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Medicaid / Private Insurance company benefits be made on my behalf to Internal Medical Diagnostics for any services furnished to me. My signature below authorizes Internal Medical Diagnostics, to release any medical information obtained during or after the delivery of services to the Health Care Financing Administration or its agents, to determine these payable benefits. All professional services rendered are charged to the patient and patient is responsible for the deductible, coinsurance, and non-covered services, that are based upon the type of insurance patient has. The necessary forms will be completed to help expedite insurance carrier payments, however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for service when rendered unless other arrangements have been made in advance with our office bookkeeper.

I hereby solemnly declare all the information provided is true to the best of my knowledge. I hereby also authorize Internal Medical Diagnostics and its employees to examine me, run necessary diagnostic procedures, prescribe medicine and treat any medical or surgical problems as deemed necessary.

Name of Beneficiary: _____ DOB: _____

Signature: _____ Date: _____