Katy Internal Medicine Associates, LLP

PATIENT INFORMATION SHEET – PLEASE PRINT INFORMATION CLEARLY

Today's Date: _____ Account# _____

FULL LEGAL NAME: _____ SOCIAL SECURITY # _____

ADDRESS: _____ APT# _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (PRIMARY) _____ (SECONDARY) _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

EMPLOYED BY: _____

EMAIL ADDRESS: _____

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

LANGUAGE, RACE, AND ETHNICITY ARE REQUIRED BY MEDICARE, NOT BY THE DOCTORS AND NURSES AT KIMA.

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

NAME OF SPOUSE: _____ DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ INSURED SS#: _____

NAME OF INSURANCE: _____ ID#: _____ GRP#: _____

PHONE # FOR PROVIDERS: _____

SECONDARY INSURANCE: _____ ID#: _____ GRP#: _____

Patient Medical Information-

1. WHY DID YOU COME IN TODAY? _____

   ARE YOU HERE FOR A WORK-RELATED OR MOTOR VEHICLE ACCIDENT? YES NO

2. DO YOU HAVE AN ADVANCED DIRECTIVE/LIVING WILL? CIRCLE ONE: YES NO

   IF NOT, WOULD YOU LIKE TO DISCUSS THIS WITH THE DOCTOR TODAY? YES NO

3. ARE YOU **ALLERGIC** TO ANY **MEDICATIONS**? CIRCLE ONE: YES NO

   MEDICATION _____ REACTION _____
   MEDICATION _____ REACTION _____
   MEDICATION _____ REACTION _____
   MEDICATION _____ REACTION _____

4. DO YOU HAVE ANY FOOD ALLEGERIES?_____IF, YES_____

5. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? PLEASE INCLUDE ALL OVER-THE-COUNTER MEDICATIONS, ORAL CONTRACEPTIVES, PRESCRIPTIONS BY OTHER PHYSICIANS, AND EYE MEDICATIONS.

Patient Signature_____ Date: _____ revised 11/01/2019

Patient Medical Information Continues

MEDICATION _____ DATE_____ DOSAGE _____

MEDICATION _____ DATE_____ DOSAGE _____

MEDICATION _____ DATE_____ DOSAGE _____

MEDICATION _____ DATE_____ DOSAGE _____

MEDICATION _____ DATE_____ DOSAGE _____

MEDICATION _____ DATE_____ DOSAGE _____

6. WHAT IS YOUR PREFERRED PHARMACY? _____

ADDRESS_____ Phone_____

7. WHAT SURGERIES HAVE YOU HAD IN THE PAST

   DATE: _____ SURGERY: _____

   DATE: _____ SURGERY: _____

   DATE: _____ SURGERY: _____

8. WHAT HAVE YOU BEEN HOSPITALIZED FOR IN THE PAST 6 MONTHS?

   DATE: _____ REASON FOR HOSPITALIZATION: _____

   DATE: _____ REASON FOR HOSPITALIZATION: _____

9. DO YOU SEE ANY SPECIALIST OR HEALTHCARE PROVIDER FOR ANY OTHER ILLNESS? YES NO

   _____

Medical History

	Yes	No		Yes	No
Diabetes			Allergies to Aspirin		
Chest Pain/Angina			Hernia		
High Blood Pressure			Seizures		
Heart Disease			Metal Implants		
Heart Attack			Dizziness/ Fainting/Syncope		
Heart Palpitations			Recent Fractures		
Pacemaker			Skin Abnormalities		
Headaches			Sexual Dysfunction		
Kidney Problems			Nausea/Vomiting		
Are you pregnant?			Ringing in your ears (Tinnitus)		
Cancer			Rheumatoid Arthritis		
Osteoporosis			Special Diet Guidelines		
Bowel/Bladder/Abnormalities			Hypoglycemia		
Urine Leakage/Incontinence			Insomnia		
Asthma/COPD			Depression		
Liver/Gallbladder			Anxiety		
Stroke/CVA/TIA			Other:_____		

Patient Signature_____ Date: _____ revised 11/01/2019

Patient Medical Information Continues

Preventive Care

Adult Physical and/or Senior Wellness Date:_____	Breast Cancer Screening Date:_____	Colorectal Cancer Screening Date:_____	Depression Screening Date:_____
Bone Density Screening/Post-Osteoporotic Fracture Evaluation Date:_____	Eye Exam Date:_____	Influenza Vaccination Date:_____	Pneumococcal Vaccination Date:_____
Diabetic Foot Exam Date:_____	Well Women Date:_____	Last Cholesterol test Date:_____	PPD Skin Test Date:_____

Family History

Member	Current Disease(s)	Health Status (good,fair,or poor)	Age	Deceased	Cause of Death
Father					
Mother					
Brothers					
Sisters					
Grandmother (maternal)					
Grandfather (maternal)					
Grandmother (paternal)					
Grandfather (paternal)					

Social History

1. HAVE YOU EVER SMOKED? _____ HOW MANY PACKS A DAY? _____
   HOW LONG DID YOU SMOKE? _____ DO YOU STILL SMOKE? _____
2. DO YOU DRINK ALCOHOL? _____
   HOW MUCH _____ HOW OFTEN? _____
3. HAVE YOU EVER USED RECREATIONAL DRUGS? _____ IF YES, WHEN_____
   WHAT IS THE NAME OF THE DRUG(S)? _____

ANY OTHER PERTINENT INFORMATION?

_____

_____

_____

HOW DID YOU HERE ABOUT US? HEALTH PROVIDER PATIENT/FRIEND INSURNACE OTHER

NAME_____

Patient Signature_____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure 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 slowly that other people could have noticed. Or the opposite – being so fidgety 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**
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 _____			

Patient Signature_____ **Date:** _____ **revised 11/01/2019**