INTERNAL MEDICINE of CHEVY CHASE, P.A.

5530 WISCONSIN AVENUE SUITE 1400, CHEVY CHASE, MD 20815
301-656-9170

PATIENT RECORD

ACCOUNT NO. _____

PLEASE PRINT CLEARLY

Name_____ Birthdate_____Age____
Address _____ City_____Zip Code_____
Home Phone_____ Birthplace_____
Marital Status_____ Cell Phone_____
Occupation_____ Business Phone_____
Employer_____ Address_____
Name of Spouse
or Responsible Party_____ Occupation_____
Employed by_____ Phone_____
Person responsible for Bills Address_____
(if not yourself)_____

Referred by_____

DRUG ALLERGIES

INSURANCE INFORMATION

Primary_____ Effective date_____ID #_____
Group #_____
Subscriber's Name _____ DOB_____ SS #_____
Secondary_____ Effective date_____ID #_____
Group #_____
Subscriber's Name _____
Social Security #_____ DOB_____ SS #_____

Check if you wish to be mailed an annual physical exam reminder. Yes☐ No☐

Please be advised that a complete itemized statement will be mailed to you at the end of each month from our automated billing service.
PLEASE BE SURE TO KEEP THESE STATEMENTS FOR INSURANCE OR TAX PURPOSES

INTERNAL MEDICINE of CHEVY CHASE, P.A.

5530 WISCONSIN AVENUE SUITE 1400, CHEVY CHASE, MD 20815
PHONE 301-656-9170 FAX 301-654-5893

Internal Medicine

GEORGE W. GRAVES, M.D.
DAVID E. ROGERS, M.D.
PASQUALE SANTINI, M.D.
DEIDRA WOODS, M.D.

I, _____, certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information inclusion medical information, for this or any related claim, to the billing agent and/or other insurance carrier. I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked by me at any time in writing.

Signature of Subscriber or Beneficiary

Identification Number

Name of Subscriber (print)

Date

INTERNAL MEDICINE of CHEVY CHASE, P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Internal Medicine of Chevy Chase, P.A.'s Notice of Privacy Practices.

Signature of Patient Date

DO WE HAVE PERMISSION TO LEAVE A MESSAGE WITH RESULTS OF MEDICAL TESTS?

YES NO

_____
Signature

_____
Phone Number

_____
Cell Number

_____
Email

INTERNAL MEDICINE OF CHEVY CHASE, P.A.

5530 WISCONSIN AVENUE • SUITE 1400 • CHEVY CHASE, MARYLAND 20815
TELEPHONE: 301-656-9170 • FAX: 301-654-5893 • 301-634-1298

** Authorization for Use or Disclosure of Protected Health Information

(Required Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

REQUEST FOR AND AUTHORIZATION TO RELEASE CLINICAL INFORMATION

Patient Name _____

Birthdate _____

TO: _____

_____

_____

FROM:

- ☐ George W. Graves, MD
- ☐ David E. Rogers, MD
- ☐ Pasquale Santini, MD
- ☐ Deidra E. Woods, MD
- ☐

I authorize you to release a copy of the following health information or medial records to Internal Medicine of Chevy Chase, P.A.

_____

_____

_____

_____

AUTHORIZED SIGNATURE

Patient Signature _____ Date _____

NOTE: If patient is unable to sign authorization form because of physical condition or age, complete the following:

☐ Patient is a minor or ☐ unable to sign because: _____

Parent Signature (or Legal or Personal Representative):

_____ Date _____ Relationship _____

MEDICAL HISTORY

Name_____Date of Birth_____

Date_____

***Medical History*:** To be filled out by patient and reviewed by your physician. Information on the history and physical examination is confidential and released only to persons you authorize in writing.

Allergies to Medication_____

Past Medical History
Major Illnesses (list, date)_____
Surgeries (appendix, tonsils, gallbladder, hysterectomy, etc, date)_____
Hospitalizations (list, date)_____
Accidents/Injuries (list, date)_____
Current Medications and dosages_____
_____
_____

Immunizations
Date of last tetanus_____
Date of Pneumococcal_____
Date of Hepatitis B vaccine_____

Habits
Smoking_____packs per day. Use of chewing tobacco_____
Alcohol_____drinks per day
~~Drugs~~_____type; _____frequency of use
Diet_____number of meals per day
Exercise_____hours/week; _____type of exercise
Do you use seatbelts?_____Do you use sunscreen?_____
Do you use a bicycle helmet?_____
Any special dietary restrictions?_____

Social history
School_____ occupation_____outside activities_____marital status_____
~~Who lives~~ in your home?_____Do you feel safe at home?_____

Travel
Have you been outside the US?_____
If so, where?_____
When?_____

Family History

	√ Living	√ Age of Death	Medical Problems of this Relative
Father			
Mother			
Siblings			

Who in your family has had (Please list relationship, i.e mother/father/MGM-maternal grandmother, etc.) :

- ☐ Diabetes
- ☐ Kidney disease
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Hepatitis
- ☐ Depression/mood disorder
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Angina
- ☐ Alcoholism
- ☐ Asthma
- ☐ Other_____
- ☐ Migraine
- ☐ Breast cancer
- ☐ Intestinal Cancer
- ☐ High cholesterol
- ☐ Osteoporosis
- ☐ Other Cancer
- ☐ Stroke
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Gallstones

Occupational Exposures (asbestos, etc.):
_____

Procedures: **Year**

- ☐ Colonoscopy _____
- ☐ Mammogram _____
- ☐ Pap smear _____

Review of Systems (Please put a √ for any question that pertains to you at this time.)

General
☐ Recent change in weight ☐ Change in appetite ☐ Have you ever used recreational drugs
☐ Fatigue ☐ Fever ☐ Weakness
☐ Nervousness/anxiety ☐ Depression ☐ Do you have any risk factors for HIV
☐ Insomnia ☐ Do you think you have an eating disorder? ☐ Have you every vomited for weight control?
_____What is your desired weight?

Skin
☐ Rashes ☐ Lumps ☐ Itching
☐ Changes in hair or nails ☐ Change in color or size of mole ☐ Unusual skin moles/growths

Head ☐ Headaches ☐ Head injury

Eyes
☐ _____Date of last eye exam ☐ Difficulty with vision ☐ Glasses or contact lenses
☐ Pain ☐ Redness ☐ Double vision
☐ Glaucoma

Ears
☐ Decreased hearing ☐ Ringing ☐ Dizziness
☐ Earache ☐ Infection ☐ Discharge
☐ Perforation ☐ Hearing aid used

Nose & Throat
☐ _____Date of last dental exam ☐ Bleeding gums ☐ Nose bleeds
☐ Frequent sore throats ☐ Hoarseness ☐ Sores in mouth
☐ Sinus problems

Neck ☐ Lumps ☐ History of radiation to thyroid gland

Breasts ☐ Lumps ☐ Pain ☐ Nipple discharge

Respiratory
☐ Cough ☐ Sputum ☐ Blood in sputum
☐ Wheezing ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Short of breath

Cardiac
☐ Heart Murmur ☐ High blood pressure ☐ Chest pain
☐ Shortness of breath ☐ Skipped beats

GI
☐ Trouble swallowing ☐ Vomiting ☐ Nausea
☐ Bulimia ☐ Change in bowel habits ☐ Blood in stool
☐ Black stool ☐ Constipation ☐ Diarrhea
☐ Use of laxatives ☐ Hepatitis ☐ Anorexia
☐ Hernia ☐ Barium enema/Colonoscopy/Sigmoidoscopy

Urinary
☐ Frequency ☐ Urgency ☐ Burning
☐ Urinating at night ☐ Blood in urine ☐ Hesitancy
☐ Urinary infections ☐ Stones ☐ Incontinence

Musculo skeletal ☐ Joint pain ☐ Joint stiffness ☐ Back pain

Neuro ☐ Fainting ☐ Blackouts ☐ Seizures

Endocrine
☐ Thyroid trouble ☐ Heat or cold intolerance ☐ Diabetes
☐ Excess Thirst ☐ Excess hunger ☐ Excess urination

Heme
☐ Anemia ☐ Have you ever had a blood Transfusion ☐ Bleeding tendency

Male
☐ Discharge from penis ☐ Sores on penis ☐ Do you use condoms every time you have intercourse?
☐ Testicular pain ☐ Testicular masses
☐ Sex with men ☐ History of sexually transmitted diseases
_____How often do you examine your testicles for masses?

Female
_____Age menses began Menses every_____days _____Days of bleeding
_____Date of last menses ☐ Spotting between periods ☐ History of sexually transmitted disease?
_____# of pregnancies ☐ Itching ☐ Date of last bone density
_____# of deliveries ☐ DES exposure ☐ Vaginal discharge
_____# of abortions (spontaneous or induced) ☐ Are condoms used every time you have intercourse?
_____Birth control method _____How often do you examine your breasts?

REVIEWED BY:_____ **DATE:**_____