

Medical History form

Name: _____

Date: _____

Past Medical History:

- ___ High Blood Pressure
- ___ High Cholesterol
- ___ History of Heart Attack or Heart Disease
- ___ Stroke or TIA (mini-stroke)
- ___ DVT/Pulmonary Embolism/Blood Clots
- ___ Diabetes: Type 1 ___ Type 2 ___
- ___ Atrial Fibrillation
- ___ Asthma/COPD
- ___ Acid Reflux/Ulcers
- ___ Hypothyroidism/Thyroid Disease
- ___ Arthritis/Autoimmune Disease/Lupus/Sjogren
- ___ Osteoporosis
- ___ Cancer (type)? _____
- ___ Sexually Transmitted Disease, type? _____
- ___ Depression
- ___ Sleep Apnea
- ___ Hepatitis/Cirrhosis of the Liver
- ___ Kidney Stone
- ___ History of COVID
- Other _____

Past Surgical History:

- ___ Tonsillectomy
- ___ Appendectomy
- ___ Biopsy (site?): _____
- ___ Pacemaker Implant
- ___ Heart Bypass: How many vessels? _____
- ___ Back or Neck Surgery
- ___ Joint Replacement
- ___ Vasectomy
- ___ Hysterectomy
- ___ Tubal Ligation
- ___ C-Section
- ___ Heart Valve Surgery
- ___ Breast Augmentation
- ___ Gall Bladder Removal
- ___ Bowel Resection
- ___ Splenectomy
- ___ Colon Polyp Removal
- ___ Hemorrhoidectomy
- Other _____

Medication Allergies: None _____

Yes, please list which ones and reaction:

Medications (List name and dose): None _____

Social History:

How long in Arizona? _____

Occupation _____

Do you smoke? ___ Never ___ Used to, but quit _____ (list year) after how many years _____
 ___ Yes, currently smoke. (How long) _____

Do you drink alcohol? ___ No ___ Yes: how many drinks per week? _____

Do you use drugs recreationally? ___ No ___ Yes
 If yes, what type and how often? _____

Do you exercise? ___ No ___ Yes. If yes, how often? _____

Sexual orientation? Straight or Heterosexual Lesbian, Gay or Homosexual Bisexual Other: _____

Family History:

Anyone in the family with the following:

- ___ Diabetes, who? _____
- ___ Colon Cancer, who? _____
- ___ Breast Cancer, who? _____
- ___ Prostate Cancer, who? _____

- ___ Heart Attack (who and age) _____
- Other _____

- Last eye exam? (month/year) _____
- Last dental exam? (month/year) _____
- Last colonoscopy? _____
- Last DEXA bone scan? _____
- COVID Vaccines? Yes No

If you are female:

- Last mammogram? _____
- Last PAP? _____
- How many pregnancies have you had? _____
- How many live births? _____



Referred By: _____

Date: _____

Name: _____

SSN#: _____ - _____ - _____

Address: _____ City _____ State _____ Zip Code _____

E-mail Address: _____

Telephone #s: Home: _____ Cell/Mobile: _____ Work: _____

Gender: M F Age: _____ Birth date _____ Single Married Divorced Widowed

Your cooperation with the following information is appreciated for national research purpose:

Race: White Hispanic/Latino Black/African American American Indian/Alaskan Native Asian
 Native Hawaiian or other Pacific Islander Other Race _____ or Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Decline or Other _____

Primary Language: English Spanish German Greek Arabic Chinese Other _____

Are you employed? No Yes, if so then: Full-time Part-time Retired

Employer _____ Employer's address _____

Insurance Information:

Primary Insurance _____ Policy Holder Name _____

Patient relationship to insured _____

SSN of Account Holder _____ Date of Birth _____

Policy # _____ Group # _____

Secondary Insurance (If applicable only); _____

*If you are a minor, who is the responsible party _____

Pharmacy Information:

Local Pharmacy _____ Phone _____

Address (or cross streets) _____

Mail Order Pharmacy _____ Phone _____ Fax _____

THANK YOU FOR ALLOWING US TO BE A PART OF YOUR HEALTHCARE TEAM!!



Acknowledgement of receipt of privacy practice notice

By signing this acknowledgement you are not agreeing or disagreeing, only stating that it was given to you for review and record purpose for the future references.

Print name here

Have received and/or been given a copy of the privacy practice for Internal Medicine of Yuma

Signature

Date

Welcome to Internal Medicine of Yuma!

It is our goal to provide patients with the best medical care possible. Internal Medicine of Yuma has a policy on tests ordered by your provider and the results of any test ordered. Results from either office procedures (biopsies, cultures, spirometry etc..) or imaging studies (MRI, CT, ultrasounds etc..) are not given over the phone. In order to obtain results, an office visit will be scheduled to review the clinical findings of the test ordered and to make further recommendations for your care.

Thank you.



CANCELLATIONS/MISSED APPOINTMENTS

Missed appointments represent a cost to us, to you and other patients who could have been seen in the time set aside for you. Cancellations are requested at least 24 hours prior to your appointment. We reserve the right to charge for missed or late cancelled appointments: \$25.00 for 15 minute visits (follow up visits) and \$75.00 for 30 minute appointments (Physicals, procedures, post hospital and new patient visits)

I have read and understand the Financial Policy. I agree to assign insurance benefits to **Internal Medicine of Yuma** whenever necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charge by the collection agency for cost of collections.

Signature of the insured/authorized representative

Date

Co-payment

*Co-pays are to be collected at the time of the office appointment.

I understand that payment is due at the time of service unless arrangements have been made and that I will be given an insurance form in order to file for reimbursement. **If for any reason I am unable to pay the co-pay due at the time of service a \$10.00 fee will be applied to my bill.** I hereby assign my insurance benefits to be paid directly to Internal Medicine of Yuma LLC. I understand that I am financially responsible for non-covered services. I also authorize Internal Medicine of Yuma LLC to release any information required to process the claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for the payment of my medical charges, including review activities related to my physician's participation with my plan.

Patient/Parent Signature

Date



EMERGENCY CONTACTS

Name: _____

Date: _____

Please list ALL the telephone numbers that **YOU** may be reached at for results of labs / studies:

Telephone numbers: Home _____

Cell: _____

Work: _____

I, _____ GIVE PERMISSION to Internal Medicine of Yuma’s office to release information from my record to the list of people listed below. Please be aware that information might include lab/imaging results, messages, and/or billing inquiries.

If you **DO ALLOW us to release such medical information please place initials under their name.

Otherwise we will contact the individual for emergency return calls ONLY.

Name: _____

Relationship: _____

Phone#: _____

**initial _____

Name: _____

Relationship _____

Phone#: _____

**initial _____

Name: _____

Relationship: _____

Phone#: _____

**initial _____

Name: _____

Relationship _____

Phone#: _____

**initial _____

Name: _____

Relationship: _____

Phone#: _____

**initial _____

Name: _____

Relationship _____

Phone#: _____

**initial _____

(Please update this form as needed with our office as changes with numbers/contacts occur)



HEALTH CARE POWER OF ATTORNEY & LIVING WILL

Combined Form

I, _____ as principal designate _____ as my agent for all matters relating to my health care including, without limitation, full power to give or to refuse consent to all medical, surgical, hospital, psychiatric and related health care. This power of attorney is effective whenever I am unable to make or to communicate health care decisions. All of my agent's actions under this power have the same effects on my heirs and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or to continue to server, I hereby appoint _____ as my agent.

In acting under this power, I want my agent to give great weight to following statements: I am in favor of trail treatment. That means I want all necessary medical care to treat my condition until, and only until, my doctor and my agents reasonably decide that I am an irreversible coma, or in a persistent vegetative state, or a locked-in state, or cannot be expected to return to a fully conscious state. If following the guidelines stated above, my doctors and my agents decide that further medical care is inappropriate.

1. I want only comfort care and I don't and I do not want to undergo artificial administration of foods or fluids.
2. I do not want to be resuscitated in case I stop breathing or my heart stop beating.

If my doctors and my agents reasonably decide that I have a terminal illness, I want all decision concerning my medical and surgical care to be made in light of the expected length of life which would results from such care and the predictable effects on me of undergoing treatment. If I cannot be expected to have a significant period of conscious life even after medical or surgical care, then I want comfort care only. (Example: I do not want any surgery or other care designed to prolong my life. I do not want artificially administered food or fluids and I do not want to be resuscitated.)

This combined health care directive is made under 836-3221 and 836-3261, Arizona Revised Statutes. It continues in effect for all who may relay on it, expects those to whom I have given notice of its revocation.

Date

Signature of mark of person making living will or granted Health care power of Attorney