# Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Acute Bridging Clinic *CIMA Breast Center *CIMA Heart Institute
*CIMA Main Office *CIMA Primary Care * Haslett Primary Care *Kozmic Family Practice
*Mason Internal Medicine *Williamston Primary Care

## PLEASE COMPLETE THIS QUESTIONNAIRE AND BRING WITH YOU TO YOUR SCHEDULED APPOINTMENT

Last name: First: Middle: Birthdate: __/___/____.

**PLEASE DESCRIBE ANY CURRENT/PRESENT PROBLEM(S):**

_____
_____
_____
_____

**PLEASE DESCRIBE ANY PRIOR MEDICAL PROBLEM(S) or DIAGNOSIS:**

_____
_____
_____
_____
_____

**LIST YOUR PREVIOUS PRIMARY CARE DOCTOR and ANY SPECIALISTS THAT YOU SEE or HAVE SEEN IN THE PAST:**

_____
_____
_____

**LIST ANY PRIOR HOSPITALIZATIONS and /or SURGERIES:**

| DATE | PROCEDURE | REASON |
|---|---|---|
| | | |
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**PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM**

| ALLERGY/MEDICATION | REACTION |
|---|---|
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**PLEASE LIST MEDICATIONS YOU ARE USING:**

| MEDICATION TAKING | DOSAGE | REASON FOR USING |
|---|---|---|
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(May use back of page for any additional information)

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**FEMALE MENSTRUAL HISTORY:** Age at Onset? _____
Usual Flow: ❑ Light ❑ Moderate or ❑ Heavy ❑ Menopause
❑ Pain or Bleeding After Sex ❑ Pain or Cramps ❑ Flushing/Hot Spells
❑ Live Births ❑ Pregnancy ❑ Miscarriages ❑ Birth Control
Number of Children: _____ Number of Boys: _____ Number of Girls: _____

## Family History: (Please check all boxes that apply in table below)

Please tell us about medical problems in your blood relatives. This can help us take better care of you.
Fill out the chart below by checking all the appropriate boxes that apply to each relative.

| | AGE (years old) | DECEASED (Y/N) | DIABETES | HYPERTENSION | HEART DISEASE/CHF/MI | STROKE | ASTHMA | CANCER | UNKNOWN | ALLERGIES | MENTAL ILLNESS | DEPRESSION | OSTEOPOROSIS | COPD | HYPERLIPIDEMIA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MOTHER | | Y/N | | | | | | | | | | | | | |
| FATHER | | Y/N | | | | | | | | | | | | | |
| MOTHERS MOTHER | | Y/N | | | | | | | | | | | | | |
| MOTHERS FATHER | | Y/N | | | | | | | | | | | | | |
| FATHERS MOTHER | | Y/N | | | | | | | | | | | | | |
| FATHERS FATHER | | Y/N | | | | | | | | | | | | | |
| BROTHERS | | Y/N | | | | | | | | | | | | | |
| SISTERS | | Y/N | | | | | | | | | | | | | |
| CHILDREN | | Y/N | | | | | | | | | | | | | |

## Social History:

**Marital Status:** Single, Married, Divorced, Separated, Widowed

**Occupation**: _____ Retired: Yes, No

**Education**: _____ Level: Graduate Degree, Undergraduate degree,

Some College, High School only

**Cigarette Use**: Never Past use Packs/day _____
Current use Packs/day _____

**Any Exposure to Second Hand Smoke:** Yes No

The Group Health Plan within the Capital Internal Medicine Associates,
PC Employee Benefits Plan complies with applicable Federal civil rights laws
and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

| | | |
|---|---|---|
| Spanish | ATENCIÓN: | si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600. |
| Arabic | ملحوظة: | بـرقم اتصـل .بالمجـان لـك تتوافـر اللغويـة المسـاعدة خدمات فـإن ،اللغـة اذكر تتحـدث كنـت إذا 1-517-374-7600 |

REV 1-2019

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**Alcohol Use**: Never used, past use, Beer, Wine, Liquor, Treatment for use

**Caffeine Use**: Never used, past use, Coffee, Tea, Cola's, ounces per day_____

**Diet**: No restrictions, Diabetic, Low Salt, Low fat/Low Cholesterol, Calorie Restriction, Fluid Restriction

**Exercise**: Type: _____ Frequency_____ Length:_____

**Illegal Drug Use**: Never used, Past use, Type: _____ Treatment Yes No

**Seat Belt Use**: Yes No **Smoke Detectors**: Yes No

**Victim of Domestic Violence**: Yes No Current Past

## Review of Systems:

(**Please circle all ROS that apply to you on the day of your visit, or in the recent past only**)

**General Health:** tiredness, fever, chills, night sweats, weight loss, weight gain,

**Skin:** rash, hives, itching, blisters, dry skin

**Eyes:** double vision, poor vision, blurred vision

**Ear, Nose, Throat:** sore throat, ringing in ears, sinus infections, bloody noses, voice changes Hearing loss, spinning, dizziness

**Neck:** thyroid masses, neck pain, stiffness

**Lungs and Heart:** shortness of breath, cough, coughing up blood, coughing up phlegm, wheezing, heart skipping, heart beating fast, pain in leg muscles when you walk, chest pressure, chest pain, chest tightness

**Digestive System:** vomiting, nausea, diarrhea, constipation, change in bowel habits, black stools, painful bowel movements, painful anal spasms, abdomen pain

**Genitals and Urinary:** frequent urination, slow urinary stream, burning or pain with urination, Unusual vaginal discharge, discharge from penis, change in sex drive

**Muscles and Joints:** pain, swelling, stiffness, decreased motion

**Diabetic Symptoms:** unusually thirsty, unusually large volume or frequent urination

**Thyroid Symptoms:** compared to others are you unusually cold or hot Yes No

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**Nervous System:** weakness, numbness, imbalance, headaches, tremor (shaking)

**Blood System:** anemia, easy bruising, unusual bleeding when you cut yourself or brush your teeth

**Infections:** Measles, Mumps, German Measles, Chicken Pox, Shingles

**Emotions:** Depression, Anxiety
Additional Comments:

_____

_____

_____

Thank you for taking the time to fill out this form!

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# Patient Preferences for Verbal Communication of Protected Health Information

Please help us to accommodate your wishes regarding how we communicate your health care by completing and signing this form. The following individuals are given permission to receive verbal information as indicated:
**Please note the below named individuals may not access, request, or receive copies of your medical records without an Authorization for Release of Medical Records signed by you.**

| NAME/RELATIONSHIP | PHONE NUMBER | TYPE OF INFORMATION |
|---|---|---|
| | | |
| | | |
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| | | |

| | | |
|---|---|---|
| ☐ Yes | ☐ No | May we leave a message on your voicemail regarding test results or medical advice? |
| ☐ Yes | ☐ No | May we leave information regarding an upcoming appointment or a request for you to call the office with another individual in your household? If yes, please indicate the individuals with who we may leave such a message.<br>☐ Spouse<br>☐ Other:_____ |
| ☐ Yes | ☐ No | May we send written correspondence in a sealed envelope to your home address? In not, please indicate an alternate address where we may send confidential communications:<br>_____ |

Policies and Limitations on Alternate Means of Communication:

- We are required to accommodate "reasonable" requests for communicating with you by alternate means. We may deny the request if we determine that it is unreasonable.
- You agree that the security and confidentiality of the confidential information sent via alternate method is your responsibility alone, and neither the physician or the practice is responsible for any inadvertent disclosures that may occur as a result of fulfilling the request.

Print Patient Name: _____

Patient Signature: _____ Patient DOB: _____

**For Office Use Only**

Patient ID: _____ Provider: _____ Date: _____

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**3955 Patient Care Dr. Suite A**
**Lansing, MI 48911**

**Phone: (517) 374-7600 Fax: (855) 505-8064**

## Authorization for Use or Disclosure of Information

*Patient Name: _____*Maiden/Other Name _____

*D.O.B._____/_____/_____ *Phone Number (_____) _____

*Patient Address: _____
Street City State Zip

I authorize_____
Healthcare Facility/Physician

To release any and all information contained in the record which may include information regarding: **Drug and/or alcohol treatment, psychological records, HIV/AIDS and other Sexually Transmitted Disease.**

Name to whom information may be released: _____
Physician/Facility/Self

---

***Please send most recent:**

☐ Entire Medical Record ☐ Discharge Summary ☐ Colonoscopy ☐ Operative Reports

☐ Radiology/Diagnostic Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Progress Notes

☐ Radiology/Diagnostic Imaging ☐ Medications ☐ Immunizations ☐ Billing Records

☐ Emergency Room Records ☐ Other (Specify): _____

***Information to Be Released (From Date: _____ To Date: _____)**

Here at CIMA we are constantly trying to improve our quality of care, if you are leaving the practice please give a brief description as to why: (optional) _____

_____

This authorization expires (Date): _____ (if no date is given this release will expire one year from date of patient's signature)

I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification.

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative (if necessary)

_____
Person Authorized to Pick-up on Patient's Behalf

This form for Authorization for Use or Disclosure of Information is designed to comply with Title 42 of Federal Regulations, Part 2 (HIPAA).

The Group Health Plan within the Capital Internal Medicine Associates, PC Employee Benefits Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

| | | |
|---|---|---|
| Spanish | ATENCIÓN: | si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600. |
| Arabic | ملحوظة: | بـ رقم اتـ صل بـ المجان. لـ كـ تـ توافـ رـ الـ لغويـ ة الـ مـ ساعدة خدمات فـ إن الـ لغة، اذكـ رـ تـ تحدث كـ نت إذا 1-517-374-7600 |

REV 12-2019

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# Authorization to Access External Health Information Databases

I authorize Capital Internal Medicine Associates, PC, to access any and/or all external databases available to health care providers in the State of Michigan, including Health Information Exchanges (HIE's) and/or interoperability systems which may contain my protected health information, on a frequency to be determined by my provider. I understand and acknowledge that these external databases will include, but not limited to, information reflecting prescription medications filled/ordered/or used by me, which will be used to verify current medications, coordinate care, and prevent drug interactions. This information will become part of my permanent medical record at Capital Internal Medicine Associates, P.C.

Name of Preferred Pharmacy: _____

Location of Pharmacy: _____

Patient Name (Printed): _____

I Consent Patient Signature: _____

I Refuse Patient Signature: _____

If Minor Patient, Parent/Guardian Signature: _____

Patient's Date of Birth: _____

Today's Date: _____

Patient Account Number (Office use only): _____