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

PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM

ALLERGY/MEDICATION	REACTION

PLEASE LIST MEDICATIONS YOU ARE USING:

MEDICATION TAKING	DOSAGE	REASON FOR USING

(May use back of page for any additional information)

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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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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

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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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Arabic	ملحوظة:	1-517-374-7600 اذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية متوافرة لك بالمجان. اتصل برقم

REV 1-2019

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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

☐ 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. ☐ Spouse ☐ 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: _____

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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REV 3-2018

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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).

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