Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Breast Center
*CIMA Main Office * Haslett Primary Care *Kozmic Family Practice
*Williamston Primary Care

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

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

BIRTHDATE: ____/____/____ PREFERRED PRONOUNS: _____

PREFERRED NAME: _____

PLEASE DESCRIBE ANY PRIOR MEDICAL PROBLEM(S) or DIAGNOSES:

_____
_____
_____
_____
_____

PLEASE LIST YOUR PREVIOUS PRIMARY CARE PROVIDER and ANY SPECIALISTS THAT YOU SEE or HAVE SEEN IN THE PAST 24 MONTHS:

_____
_____
_____

PLEASE LIST ANY PRIOR HOSPITALIZATIONS and /or SURGERIES:

DATE	PROCEDURE	REASON

PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM:

ALLERGY/MEDICATION	REACTION

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS YOU CURRENTLY TAKE:

MEDICATION/SUPPLEMENT	DOSAGE	HOW OFTEN	REASON FOR TAKING

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FEMALE MENSTRUAL HISTORY: Age at onset? _____

Usual Flow: ☐ Light ☐ Moderate ☐ Heavy

☐ Pain or Bleeding after sex ☐ # of Pregnancies: _____ ☐ # of Miscarriages: _____

☐ #Live Births: _____ ☐ # of Girls: _____ ☐ # of Boys: _____

Family History: (Please check all boxes that apply in the table below)
Please tell us about medical problems in your blood relatives.

	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													
MOTHER'S MOTHER		Y/N													
MOTHER'S FATHER		Y/N													
FATHER'S MOTHER		Y/N													
FATHER'S FATHER		Y/N													
BROTHERS		Y/N													
SISTERS		Y/N													
CHILDREN		Y/N													

Sex assigned at Birth: _____ **Gender Identity**: _____ **Sexual Orientation:** _____

Marital Status: Single Married Divorced Separated Widowed Life Partner

Occupation:_____ Retired: Yes No

Education:_____

Level: Graduate Degree Undergraduate Degree Some College High School only

Cigarette Use: Never Past use Packs/day _____ # of years_____

Current use: Packs/day _____Age Started_____

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Quit Smoking: Month:_____ Year:_____
Exposure to Secondhand Smoke: Yes No

Alcohol Use: Never used Past use Beer Wine Liquor Treatment for use_____

Caffeine Use: Never used Past use Coffee Tea Soda/Pop Ounces per day: _____

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

Exercise: Type:_____How Often:_____Length of Time_____

Illicit 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, change in vision

Ear, Nose, Throat: sore throat, ringing in ears, sinus pressure, bloody noses, hearing loss

Neck: thyroid masses, neck pain, stiffness

Lungs and Heart: shortness of breath, cough, coughing up blood, wheezing, leg pain when walking, chest pressure/ pain/tightness

Digestive System: vomiting, nausea, diarrhea, constipation, change in bowel habits, painful bowel movements, abdomen pain

Genitals and Urinary: frequent urination, burning/pain with urination, unusual vaginal discharge, discharge from penis, change in sex drive

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

Endocrine: unusually thirsty, increased amount of urine or frequent urination, urination during night, unexplained weight loss, unusually cold or hot

Nervous System: weakness, numbness/tingling, imbalance, headaches, tremor (shaking), dizziness

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

Infections: measles, mumps, chicken Pox, shingles, MRSA

Emotions: depression, anxiety, trouble sleeping

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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? If not, please indicate an alternate address where we may send confidential communications: _____

Preference on communication of appointment reminders (Please Circle): Text, Call, Portal Message
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 provider nor the practice is responsible for any inadvertent disclosures that may occur as a result of fulfilling the request.

Primary Care Provider: _____

Emergency Contact: Name_____ **Phone Number:** _____

DPOA/Guardian (if applicable): _____

Print Patient Name: _____

Patient Signature: _____ Patient DOB: _____

For Office Use Only

Patient ID: _____ Provider: _____ Date: _____

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:	إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-517-374-7600

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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 Report
(5 Years of Records provided, unless otherwise specified)

☐ 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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