COLUMBUS INTERNAL MEDICINE ASSOCIATES

COLUMBUS REGIONAL HEALTH

Thank you for contacting Columbus Internal Associates to establish as a patient. Completion of the attached paperwork is necessary before your first appointment. We will review your medical needs to be certain that they are within the scope of an internal medicine practice. We must receive your packet by the date noted on the following page for proper review or your appointment will be rescheduled.

Providing your prior medical records can be helpful in evaluating past health issues and planning your ongoing care. Most physician offices will charge you to provide printed medical record information. Being specific when you request records from other offices will save you expense. Below is a list of health records that your CIMA physician will find valuable.

- Colonoscopy and mammogram reports - most recent, if applicable
- Cardiac catheterization and/or echocardiogram report, if applicable
- MRI , CT scan or x-ray report - within the last 18 months
- Lab results – within last 12 months
- Last consultation office visit with a cardiologist, oncologist, gastroenterologist, etc., if applicable

We will work with you to achieve a healthy life and to serve you as efficiently as possible. As your primary care provider, we will discuss with you the latest recommendations for preventive care (tests, vaccinations), appropriate for your age, and will expect you to follow-through with preventive care ordered for you.

Should you have a chronic medical condition (hypertension, diabetes, lung disease, heart failure, i.e.), or take any prescription medications, your physician will need to see you periodically to evaluate your condition. The time between these evaluation visits will be determined by your physician.

We write prescriptions only during office visits. Keeping your scheduled visits will ensure that your prescription renewal needs are met.

During your first visit at Columbus Internal Medicine, your physician will not write prescriptions for narcotics, stimulants, benzodiazepines, sleeping pills or similar controlled medications. To safely manage your care, your current health status and previous care records must be evaluated before a decision about prescribing medications with a high risk of dangerous side effects can be made.

4050 Central Avenue • Columbus, IN 47203 • (812) 376-9427 • (812) 378-6174 Fax

Important Preparation

Please return this completed packet to the office by: _____.

If your packet is not received by this date, we will contact you to reschedule the appointment.

Your appointment is scheduled on _____, at _____,

Your Primary Care Physician is Dr. _____.

Perfume, cologne or scented lotions cause breathing problems for many of our patients. Please do not wear these when visiting our office.

A 15 minute early arrival is appreciated.

Always

1. Bring all current medication bottles.
2. Bring all insurance cards.
3. Bring your driver's license.
4. Bring a list of health concerns and questions for your physician.

Thank you for your help making your visit time effective and efficient. We anticipate a long, healthy relationship.

Columbus Internal Medicine Associates

Please answer all questions in this packet carefully.
If a question does not apply to you, answer with "N/A."

Patient Name :_____ Nickname:_____

Address :_____

City, State, Zip :_____

Date of birth :_____ SSN:_____

Sex: M ☐ F ☐ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____

Emergency Phone: _____ Relationship: _____

EMPLOYMENT

Patient's Employer:_____ Full/Part Time:_____

INSURANCE

Please attach a copy of the front and back of all cards

Primary Insurance:_____

Subscriber: _____

ID:_____ Group:_____

Secondary Insurance:_____

Subscriber:_____

ID:_____ Group:_____

Tertiary Insurance:_____

Subscriber:_____

ID:_____ Group:_____

Please bring your insurance and identification cards with you to all visits.

INSURANCE SUBSCRIBER INFORMATION

(If different than the patients)

Subscriber Name: _____

Relationship to patient: _____

Address : _____

City, State, Zip : _____

Date of birth : _____ SSN: _____

Employer: _____ Full/Part time: _____ Sex: M ☐ F ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

ADDITIONAL INFORMATION

Visually Impaired: Yes ☐ No ☐ Hearing Impaired: Yes ☐ No ☐

Preferred language _____ Needs Interpreter? Yes ☐ No ☐

Race _____ Religion _____

Military Service? _____ if yes, branch of service _____

COMMUNICATION PREFERENCES

What is your preferred method of communication?

No preference ☐ Do not contact ☐ Mail ☐ Phone ☐ Email ☐ My Chart ☐

Would you like to receive text messages? _____

Would you like to be contacted about research opportunities? _____

Health History

Please initial if you take no medications: _____
If you take medications, please list all below.

Current Medications

Medication Name	Time of day taken (ex: am, lunch, bed)	Total dose taken (mg) at this time	Who Prescribed

If a question does not apply to you, answer with "N/A".

Vitamins / Supplements

Vitamin / Supplement Name	Dose Taken (mg)	When Taken

Allergies or Severe Intolerance of Medications /Latex/ Other

Substance	Reaction

Health Screening Exams

Exam	Date of Exam	Who Ordered	Issues
Eye Exam			
Mammogram			
Colonoscopy			
Aortascan			
PSA			

If a question does not apply to you, answer with "N/A".

Vaccinations

Name of Vaccine	Date last Received	Where Received
Influenza (Flu)		
Tetanus		
Tetanus / Diptheria		
Tetanus/Diptheria/Pertussis		
Shingles		
Pneumonia		
Prevnar 13 (Supplement to pneumonia)		
Gardisil: 1st vaccine		
Gardisil: 1st vaccine		
Gardisil: 1st vaccine		
Hepatitis A : 1st vaccine		
Hepatitis A : 2nd vaccine		
Hepatitis B : 1st vaccine		
Hepatitis B : 2nd vaccine		
Hepatitis B : 3rd vaccine		

If a question does not apply to you, answer with "N/A".

Other Physicians Seen Regularly

Physician Name	Specialty	Last Visit Date

Surgeries

Name of Surgery	Date Performed	Where Performed	Who Performed

Life Style

Do you smoke? ( ) No ( ) Yes If yes, packs per day?_____

Have you ever smoked? ( ) No ( ) Yes If yes, when did you quit? _____

Do you exercise? ( ) No ( ) Yes If yes, what type of exercise? _____

How often and how minutes? _____

Do you drink alcohol? ( )No ( ) Yes If yes, drinks per day? _____

If yes, drinks per month? _____

Do you always wear your seatbelt? ( )Yes ( ) No

Do you have an Advanced Care Directive or Living Will? ( )Yes ( ) No

If yes, who is the decision maker: _____

Phone number of the decision maker?_____

If a question does not apply to you, answer with"N/A".

Family History

	Father	Mother	Sibling 1	Sibling 2	Sibling 3
			Male / Female	Male / Female	Male / Female
Living	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
If No, age at and cause of death					
Illness					
Illness					
Illness					
Illness					
Illness					

Do you have a problem with any of the following?

General	Yes	No
Fever		
Chills		

Skin	Yes	No
Rash		
New skin problems		
Change in mole		

Eyes	Yes	No
Blurred vision		
Change in visual acuity		

Ears	Yes	No
Pain in ears		
Difficulty hearing		

Nose	Yes	No
Nasal discharge		
Nasal congestion		
Nose bleeds		

Mouth	Yes	No
Sore throat		
Difficulty swallowing		

Neck	Yes	No
Pain in neck		
Swelling in neck		

Respiratory	Yes	No
Shortness of breath		
Cough		
Wheezing		

Cardiovascular	Yes	No
Palpitations		
Chest pain		
Shortness of breath lying down		
Swelling of legs		
Fainting or passing out		
Pain in legs while walking		

Gastrointestinal	Yes	No
Nausea or vomiting		
Diarrhea		
Constipation		
Abdominal pain		
Black tarry stools		
Bright red blood in stools		

Genitourinary	Yes	No
Burning on urination		
Frequent urination		
Difficulty starting urine stream		
Leaking of urine		

Musculoskeletal	Yes	No
Joint or muscle pain		
Back pain		

Neurological	Yes	No
Numbness or tingling of arms or legs		
Weakness of arms or legs		

Psychiatric	Yes	No
Depression		
Anxiety		
Substance abuse		
Suicide attempts		

Endocrine	Yes	No
Heat or cold intolerance		
Weight loss or weight gain		
Increasing thirst		

Hematology or Immunology	Yes	No
Bleeding or bruising problems		
Recurrent infections		

For Men Only	Yes	No
Problems with erections		

For Women Only	Yes	No
Bleeding or discharge from breast		
Lump in breast		