Greenfield Internal Medicine
MEDICAL HISTORY

Name:_____ Family Physician:_____

Home Address:_____

Age:_____ Marital Status:_____ Emergency Contact:_____

Telephone: (H) _____ (W) _____ Occupation: _____

Past Medical History: *Have you ever been diagnosed with any of the following conditions?*			
Hypertension/High Blood Pressure?	Yes	No	If so, when?
Diabetes/High Blood Sugar?	Yes	No	If so, when?
Cancer/TB/Tuberculosis?	Yes	No	If so, when?
Heart Disease/Heart Attack?	Yes	No	If so, when?
Hypercholesterolemia/High Cholesterol?	Yes	No	If so, when?
Stroke/TIA/Seizures/Alzheimer's?	Yes	No	If so, when?
AIDS/HIV infection?	Yes	No	If so, when?
Any other medical problems?	Yes	No	If so, what and when?
Past Surgical History: *Have you ever had any of the following operations?*			
Tonsillectomy/Appendectomy?	Yes	No	If so, when?
Gallbladder Surgery/Cholecystectomy?	Yes	No	If so, when?
Hernia Repair/Back Surgery?	Yes	No	If so, when?
Thyroidectomy/Thyroid Surgery?	Yes	No	If so, when?
Hip/Knee/Joint Surgery?	Yes	No	If so, when?
Eye Surgery/Cataract Surgery/Sinus Surgery?	Yes	No	If so, when?
Heart Surgery/Bypass Surgery/Valve Surgery?	Yes	No	If so, when?
Hysterectomy/Ovarian Surgery/Tubes Tied?	Yes	No	If so, when?
Breast Surgery?	Yes	No	If so, when?
Vasectomy/Prostate Surgery?	Yes	No	If so, when?

Any other surgeries please list below:
Date Hospitalized:_____ For what:_____
Date Hospitalized:_____ For what:_____
Date Hospitalized:_____ For what:_____
Date Hospitalized:_____ For what:_____

Do you have any drug allergies or intolerances or any allergies to food, iodine, seafood, eggs, etc.?
Please list below:

_____
_____
_____
_____

Are you currently taking any medications? *Yes* *No* *If so, please list below:*

Name Of Medication	Dose	How Often Taken?	Date Prescribed	Reason

Is there any history of diabetes, hypertension, heart disease, cancer, TB, stroke, osteoporosis, or Alzheimer's in your family? If so, please list:_____
Below, please list current age and current health status of family members, if deceased-please list age when died:

Age(s)	Living	Health Status	Cause Of Death
Father:	Yes No		
Mother:	Yes No		
Brother(s):	Yes No	_____	_____
	Yes No	_____	_____

Sister(s):	Yes No Yes No			
Any family history of Breast Cancer?		Yes	No	If so, who?
Any family history of Ovarian Cancer?		Yes	No	If so, who?
Any family history of Testicular Cancer?		Yes	No	If so, who?
Any family history of Prostate Cancer?		Yes	No	If so, who?
Any family history of Colon Cancer?		Yes	No	If so, who?
Personal History:				
Do you have any children?		Yes	No	If so, how many?
Are you retired?		Yes	No	
Do you have a living will?		Yes	No	
Are you an organ donor?		Yes	No	
Previous occupations?				
Have you every smoked?		Yes	No	
If so, do you still smoke?		Yes	No	If so, how many packs per day?
If you quit, when?				
Do you smoke cigars/chew snuff?		Yes	No	
Are you exposed to second hand smoke?		Yes	No	
Do you drink any alcohol?		Yes	No	If so, what and how much
Have you ever used any illegal drugs?		Yes	No	If so, when?
Have you ever received a blood transfusion?		Yes	No	If so, when
Are you sexually active?		Yes	No	
Do you drink coffee?		Yes	No	If so, how much?
Do you have any pets?		Yes	No	If so, what type?
Review of Systems/General:				
Weight change of more than 5 lbs. in the last yr.?		Yes	No	If so, how much?
Is your appetite abnormal?		Yes	No	If so, in what way?
Are you more thirsty than normal?		Yes	No	
Have you had fevers/chills in the last 3 months?		Yes	No	
Have you had night sweats in the last 3 months?		Yes	No	
Ever have a bleeding disorder/anemia/bruising?		Yes	No	If so describe:
Do your gums bleed easily?		Yes	No	
Are you more tired than usual?		Yes	No	
Do you have trouble sleeping at night?		Yes	No	
How many pillows do you sleep on?				
Do you wake up at night short of breath?		Yes	No	If so, how often?
Do you have to get up every night to urinate?		Yes	No	If so, how often?
Skin: Have you had a recent rash/itching?		Yes	No	If so, where?
Any change in the texture of your skin/hair?		Yes	No	
Have you ever had skin cancer/melanoma?		Yes	No	
Have you had a change in any skin lesion/mole?		Yes	No	If so, where
Have you ever had shingles/herpes/cold sores?		Yes	No	If so, where & when?
Eyes: Do you wear glasses/contacts?		Yes	No	
Have you had a recent change in your vision?		Yes	No	
Do you have blurred vision/double vision/eye pain?		Yes	No	
Do you have cataracts/glaucoma?		Yes	No	
When was your last eye exam?				
Ears: Do you have any hearing problems?		Yes	No	If so, what type?
Do you have any ear ringing/buzzing/vertigo?		Yes	No	If so, when did it start?
Do you have any ear pain or ache?		Yes	No	If so, when did it start?
Nose: Do you have problems smelling/or do you snore?		Yes	No	If so, describe:
Have you had recent nosebleeds/sinus problems?		Yes	No	
Oral Cavity: Do you have any problem tasting foods?		Yes	No	If so, when did it start?
Do you have problems with your teeth?		Yes	No	If so, what type?
Do you have dentures/gum disease/oral ulcers?		Yes	No	
Have you had recent sore throats/hoarseness?		Yes	No	If so, when?

Neck: Do you have any neck pain/history of neck injury?	Yes	No	
Do you have any masses in your neck?	Yes	No	
Have you ever had a thyroid problem?	Yes	No	If so, when?
Respiratory: Have you ever had any lung disease?	Yes	No	
Do you get short of breath at rest or with exertion?	Yes	No	
Do you have a cough or wheezing?	Yes	No	If so, for how long?
Have you been coughing up any phlegm/blood?	Yes	No	If so, what color?
Have you ever had asthma/bronchitis/pneumonia?	Yes	No	If so, when?
Have you ever had emphysema?	Yes	No	If so, when?
Have you ever had a blood clot in your leg or lung?	Yes	No	If so, when?
Have you ever worked around asbestos?	Yes	No	If so, when?
Have you ever had a Chest X-ray?	Yes	No	If so, when?
Cardiac: Have you ever had a heart problem:	Yes	No	
Have you had chest pains, chest burning or pressure?	Yes	No	If so, when?
Have you ever had angina/heart attack/MI?	Yes	No	If so, when?
Have you ever had heart failure (CHF)?	Yes	No	If so, when?
Do you have palpitations (skipping/racing heart)?	Yes	No	If so, when?
Have you been dizzy/blacked out?	Yes	No	If so, when?
Have you ever had a heart murmur/rheumatic fever?	Yes	No	
Have you ever had Mitral Valve Prolapse?	Yes	No	
Do you get pains in your legs with walking?	Yes	No	
Do your feet/ankles swell?	Yes	No	If so, when?
Have you ever had an EKG/Stress Test/Cardiac Cath?	Yes	No	If so, describe:
Gastrointestinal: Do you experience heart burn?	Yes	No	If so, when?
Do you have any difficulty or pain with swallowing?	Yes	No	If so, describe
Have you had excessive belching/bloating?	Yes	No	
Have you had any nausea/vomiting/vomiting of blood?	Yes	No	If so, when?
Have you ever had an ulcer/gastritis?	Yes	No	If so, when?
Do you have any food intolerances/abdominal pains?	Yes	No	If so, which foods?
Have you ever had hepatitis/jaundice?	Yes	No	If so, what type?
Have you ever had gallbladder disease/stones?	Yes	No	If so, when?
Have you ever had liver disease/cirrhosis?	Yes	No	If so, when?
Have you had any abdominal swelling?	Yes	No	If so, when?
Have you ever had pancreatitis?	Yes	No	If so, when?
Have you ever had diverticulosis / diverticultis?	Yes	No	If so, when?
Do you have any hernias?	Yes	No	If so, when?
Any change in your bowel habits/abnormal stools?	Yes	No	If so, what change?
Do you have diarrhea/constipation?	Yes	No	
Have you noted any rectal bleeding/black stools?	Yes	No	If so, when?
Do you have hemorrhoids?	Yes	No	If so, are they causing any problems?
Have you ever had your colon evaluated? (Examples: Barium enema, Flexible Sigmoidoscopy or Colonscopy	Yes	No	
Genitourinary: Have you had urinary tract infections?	Yes	No	If so, when?
Do you have any history of kidney disease/stones?	Yes	No	If so, when?
Have you ever had any type of venereal disease (VD)?	Yes	No	If so, when?
Do you have any burning when you urinate?	Yes	No	
Do you have to urinate more than usual?	Yes	No	
Do you have urinary incontinence (loss of control)?	Yes	No	If so, when?
Do you have blood/pus/unusual color in your urine?	Yes	No	If so, describe:
Do you use any form of birth control?	Yes	No	If so, what type?
Have you ever had any genital sores/ulcers?	Yes	No	If so, when?
Have you had any sexual difficulties?	Yes	No	If so, what type?
Are you currently still menstruating?	Yes	No	
Date of last menstrual period?			
Date of last pelvic? PAP smear?			

Do you have any vaginal bleeding/discharge?	Yes	No	
Do you have any pelvic pain/pain with intercourse?	Yes	No	
Do you perform self breast exams monthly?	Yes	No	If not, how often?
Have you had any change in your breasts?	Yes	No	If so, describe:
Any change in the skin of your breasts?	Yes	No	If so, describe:
Have you had any change in your nipples?	Yes	No	If so, what change?
Have you had any nipple discharge?	Yes	No	If so, when?
Do you have any lumps in your breasts/under arm?	Yes	No	If so, when first noticed?
Have you had any breast pain/tenderness:	Yes	No	If so, when first noticed?
Have you ever had a mammogram?	Yes	No	If so, date of last one:
Urologic: (Men only) (Women, please continue at Musculoskeletal section below)			
Have you ever had any discharge/sores?	Yes	No	If so, when?
Do you perform self testicular exams monthly?	Yes	No	If so, how often?
Have you noted any testicular pain/masses:	Yes	No	
Have you ever had a prostate problem?	Yes	No	
When was your last prostate exam? _____ **By whom?**			
Have you ever had a prostate blood test (PSA)?	Yes	No	If so, when / where?
Do you have any urinary hesitancy / urgency / dribbling / incontence?			
Musculoskeletal: (Men and Women)			
Do you have frequent backaches?	Yes	No	If so, describe:
Have you ever broken a bone / or have arthritis?	Yes	No	If so, which one (s)?
Do you have painful muscles / muscle weakness:	Yes	No	If so, where?
Do you have any joint pain / stiffness?	Yes	No	If so, where?
Do you have osteoporosis/are you losing height?	Yes	No	If so, where?
Neurological: which had do you write with? Left or Right			
Do you have headaches / migraines:	Yes	No	If so, how often?
Have you ever had a seizure / convulsion?	Yes	No	If so, when?
Do you have any weakness / paralysis?	Yes	No	If so, describe:
Have you had any sensory changes?	Yes	No	If so, describe:
Any problems with coordination / tremors?	Yes	No	If so, describe:
Any change in your memory?	Yes	No	If so, describe:
Have you ever had any head trauma?	Yes	No	If so, when?
Have you ever had a stroke / mini stroke / TIA?	Yes	No	If so, when?
Have you ever had slurred speech?	Yes	No	If so, when?
Preventive Medicine: How often do you exercise weekly: _____ describe your exercise:			
What percentage of the time do you wear your seatbelt? _____ %			
Have you ever had your cholesterol checked?	Yes	No	If so, when? _____ Result: _____
Have you ever had a skin test for TB i.e. (PPD)?	Yes	No	If so, result: Positive __ Negative __ Date: _____
Do you have a hazardous occupation / hobby?	Yes	No	If so, what?
Do you have smoke detectors in your house?	Yes	No	
Do you have carbon monoxide detectors?	Yes	No	
Have you had your home tested for radon?	Yes	No	
Have you ever been the victim of physical abuse?	Yes	No	
Vaccinations: Date of last tetanus shot? _____			
Have you ever had pneumovax (Pneumonia shot)?	Yes	No	If so, date of last shot:
Have you ever had the flu shot?	Yes	No	If so, date of last shot:
Have you ever had Hepatovac (Hepatitis vaccine)?	Yes	No	If so, when?
Behavioral Health: Are you under a lot of stress?	Yes	No	If so, describe:
Have you ever had a psychiatric illness?	Yes	No	If so, when?
Have you ever thought about / attempting suicide?	Yes	No	If so, when?
Do you have problems with anxiety / depression?	Yes	No	If so, describe:

Thank you for completing this form!

Patient Name_____ **Date of Birth**_____

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature from the authorized professional staff of Greenfield Internal Medicine for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care.

I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available.

It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment to Greenfield Internal Medicine of any medical benefits, which would otherwise be payable to me and which were established by my insurance company. The amount paid to Greenfield Internal Medicine shall not exceed the practice's regular charges for the services.

I also authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Medicare Agreement

The information provided by me in applying for payment of Social Security benefits is true and correct.

I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to Greenfield Internal Medicine. In the event the physician does not receive such payment, I authorize such physician to submit a claim to Medicare on my behalf.

If my current policy prohibits direct payment to, Greenfield Internal Medicine, I hereby direct the check made out to me and mailed to: Regional Health Services, Inc., 717 State Street, Suite 16, Erie, PA 16501

Payment Agreement

Our office requests that you read your insurance policy and be fully aware of any limitations of the benefits provided. You should be aware that this insurance agreement is between you and the insurance company. We will gladly help you, but it is your responsibility to know the limitations of your policy. Any charge incurred beyond the reimbursement of your policy will be your financial responsibility.

I have read the above and understand my financial obligation.

Patient Signature _____ Date_____

Spouse/Guarantor Signature _____Relationship to Patient _____

Witness _____ Date _____

Patient's Name:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Hamot Health Foundation's Notice of Privacy Practices.

_____ _____

(Signature of Patient/Legal Representative) (Date)

If you are the legal representative of the person listed above, please note the basis for your authority and provide appropriate documentation:

☐ Power of Attorney ☐ Guardianship Order

☐ Parent of Minor ☐ Other_____