

Office Hours:
Monday – Friday: 8 am – 5 pm

Welcome to our practice. We are pleased that you have chosen Internal Medicine Associates of Olathe to provide care for you and your family. Your visit to our office is meant to be a pleasant experience and we ask for your assistance in establishing a good medical relationship. Proper patient registration is important. If this is your first visit, please arrive 20 minutes early. At each visit, please have your current insurance card and photo ID available at check-in. Any applicable co-pay is also required at the time of check-in (as in accordance with insurance guidelines).

For ease of registration, please return the completed forms to Internal Medicine Associates of Olathe three (3) business days prior to your appointment. For your convenience, you may also fax all forms to the following secure fax number – 913-782-1574.

Patient Name: _____ Today's Date: _____
Home address: Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell Phone: _____ Work Phone: _____
Referring Physician: _____ Primary care physician: _____
Birth Date: _____ Sex: M F
Marital Status: Single Married Divorced Widowed
Social Sec #: _____

Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

Patient name: _____ Date: _____

Patient Medical History – Please check all that apply to your medical history

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diverticulosis/Diverticulitis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Back/Joint Problems | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Colon/Bowel Problems | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Prostate Enlargement/Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Strokes/TIA |
| <input type="checkbox"/> Crohn's/Ulcerative Colitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | |

Surgical History – Please check all that apply to your surgical past

- | | |
|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Orthopedic (knee/hip) |
| <input type="checkbox"/> Breast Lump/Mastectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Laparoscopy | |

Family History – Please check all that apply to your family medical history

- | | | | | |
|--|--------|--------|---------|--------|
| <input type="checkbox"/> Breast Cancer | Mother | Sister | | |
| <input type="checkbox"/> Colon Polyps/Colon Cancer | Mother | Father | Brother | Sister |
| <input type="checkbox"/> Coronary Artery Disease | Mother | Father | Brother | Sister |
| <input type="checkbox"/> Diabetes | Mother | Father | Brother | Sister |
| <input type="checkbox"/> Gastric Cancer | Mother | Father | Brother | Sister |
| <input type="checkbox"/> Liver Disease | Mother | Father | Brother | Sister |
| <input type="checkbox"/> Pancreatic Cancer | Mother | Father | Brother | Sister |
| <input type="checkbox"/> Ulcerative Colitis/Crohns | Mother | Father | Brother | Sister |

Social History – Please circle

Marital status: Single Married Divorced Widowed

Smoking/Tobacco Use: Quit No Yes Packs per day _____ Number of years _____

Alcohol Use : Quit No Yes

If yes what type: beer liquor wine how many drinks per day? _____

Caffeine Use Number of cups/drinks a day? _____

Exercise: No Yes How frequently: _____

Preventative Screenings – Please check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Colonoscopy (>age 50) | <input type="checkbox"/> Mammography (women age 40-74) |
|--|--|

Date: _____

Date: _____

Any Other Tests

Physician/Provider Signature: _____ Date: _____

Patient name: _____ Date: _____

Please indicate if you are *CURRENTLY* having any of the symptoms listed below. By not selecting a symptom you are denying having this problem at this time.

- Constitutional** Decrease in appetite Fatigue Fever Night sweats Weight loss Weight gain
- Eyes/ENT** Blurred or double vision Diminished Vision Drainage Hoarseness
 Hearing loss or ringing Chronic sinus problems Nose bleeds
- Respiratory** Chronic Cough Wheezing Shortness of breath
- Endocrine** Increased thirst Cold/Heat intolerance Breast Discharge Change in menstrual cycle
- Cardiovascular** Chest Pain Palpitations Leg Swelling Pacemaker
- Hematology** Coumadin treatment Nose Bleeds Easy bruising Swollen glands Anemia
- Genitourinary** Frequent urination Burning/painful urination Blood in urine Decreased flow
- Musculoskeletal** Painful joints Joint swelling Muscle cramps Back pain
- Skin** Itching Rash Hives Skin Cancer
Dry Skin
- Neurological** Dizzy or light headed Epilepsy Numbness or tingling Memory loss Difficulty speaking
- Psychiatric** Depression Anxiety Insomnia Stress Mood changes

Medications: List all medications you presently take. (include dosage and how often)

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Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Mail Order: _____

Non-Traditional Medications Please list herbs and/or dietary supplements

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| | |

Allergies: Drug/Agent

Reaction

| Drug/Agent | Reaction |
|------------|----------|
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| | |

Physician/Provider Signature: _____ Date: _____