Welcome To Thunderbird Internal Medicine

Patient Name: ___________________________________ Date of Birth:_____________

Mailing Address: ____________________________City: ________ State: _____ Zip Code: ________

Home Phone: ________________ Cell Phone: ________________Work Phone: _____________

Social Security #:_______________ Gender: ________ E-mail: __________________________

Pharmacy Name: ______________________ Pharmacy Address: _________________________________

Marital Status:	Race:	Ethnicity:	Language:
☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated	☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ American Indian ☐ Other ☐ Refused	☐ Hispanic ☐ Not Hispanic ☐ Refused	☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin Chinese ☐ Hungarian ☐ Other

Are you currently employed? Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐

Employer: _______________________________________Phone#: ____________________________

Address: ________________________ City: ______________ State: _____ Zip Code: ___________

**Do you have insurance through YOUR employer? Yes ☐ No ☐

Primary Insurance: ____

Policyholder Name: _________________________________ Relationship to patient: ____________

Policyholder date of birth: _________________ Policyholder's Employer:______________________

Policy/ID #: ____________________________ Group #: ____________________________________

Insurance Company Address: ____

City: ________________________ State: ________________ Zip Code: ______________________

Secondary Insurance: ____

Policyholder Name: _________________________________ Relationship to patient: ____________

Policyholder date of birth: _________________ Employer: _________________________________

Policy/ID #: ____________________________ Group #: ___________________________________

Insurance Company Address: ____

City: ________________________ State: ________________ Zip Code: ______________________

****Do you have AHCCCS or Tertiary (3rd) Insurance**? ☐Yes ☐No

If yes, Plan Name/ID#: ____

Patient/Parent/Guardian Signature:

____**Date:**_______________________

THUNDERBIRD INTERNAL MEDICINE
SUMMIT **MEDICAL** GROUP
ARIZONA

Name: ________________________ DOB: ________________________

What are the **most important** issue you want to discuss at today's office visit?

1. ____
2. ____

MEDICATIONS	Dose	Frequency	Reason taking
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________

PAST OR PRESENT MEDICAL CONDITIONS - CHECK ALL THAT APPLY

- ◻ Hypertension
- ◻ Type 2 or 1 diabetes
- Diabetes Complications:
  - ◻ Kidney (nephropathy)
  - ◻ Nerve (neuropathy)
  - ◻ Eye (retinopathy)
- ◻ Hyperlipidemia
- ◻ Hypothyroidism
- ◻ Thyroid nodule / goiter
- ◻ Elevated blood sugar
- ◻ Osteopenia / Osteoporosis
- ◻ Menopause
- ◻ Coronary artery disease / heart attack
- ◻ Atrial fibrillation
- ◻ Carotid stenosis
- ◻ Blood vessel disease (PVD)
- ◻ COPD / Asthma
- ◻ Asbestos exposure
- ◻ DVT / Pulmonary embolism
- ◻ Obstructive sleep apnea
- ◻ Positive TB skin test (PPD)
- ◻ Restless leg syndrome
- ◻ Chronic kidney insufficiency
- ◻ Gastroesophageal reflux
- ◻ Barrett's esophagus
- ◻ Crohn's / Ulcerative Colitis
- ◻ Celiac sprue
- ◻ History of colon polyps
- ◻ Hepatitis B or C
- ◻ Irritable bowel disease
- ◻ Rheumatoid arthritis
- ◻ Degenerative arthritis
- ◻ Psoriasis
- ◻ Systemic lupus erythematous
- ◻ Gout
- ◻ Chronic pain
- ◻ Alzheimer's / dementia
- ◻ Epilepsy /seizure
- ◻ Stroke (CVA)
- ◻ Parkinson's disease
- ◻ Peripheral neuropathy
- ◻ Migraine or Headaches
- ◻ Kidney stones
- ◻ Large prostate (BPH)
- ◻ Anemia
- ◻ Anxiety / depression
- ◻ Allergies
- ◻ Glaucoma
- ◻ Macular degeneration
- ◻ Low vitamin B12 or D
- ◻ Chickenpox
- ◻ Cancer: ______________________ ______________________
- ◻ Other: ______________________ ______________________ ______________________

Women only:
Number of Pregnancies _____ # of live births _____ # of Miscarriage/Abortion _____

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ALLERGIES TO MEDICATIONS OR FOOD

Medications / Food	Reaction
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________

SURGERIES – CHECK ALL THAT APPLY

- ☐ Appendectomy
- ☐ Gallbladder surgery
- ☐ Vasectomy
- ☐ Prostate Surgery
- ☐ Hysterectomy
- ☐ Ovary Removal
- ☐ Breast Surgery
- ☐ Breast Biopsy
- ☐ Heart Bypass/Stent
- ☐ Bariatric Surgery
- ☐ C-section
- ☐ Thyroid Surgery
- ☐ Back/Neck Surgery
- ☐ Cataract Removal
- ☐ Tonsillectomy
- ☐ Transplant (list): ______________________
- ☐ Hernia (list): ______________________ ______________________
- ☐ Joint Surgery (list): ______________________ ______________________
- ☐ Other Surgery (list): ______________________ ______________________ ______________________ ______________________ ______________________

FAMILY HEALTH HISTORY

	Major medical problems	Age of death	Cause of death
Mother	____________________	___________	____________________
Father	____________________	___________	____________________
Sibling (#_____)	____________________	___________	____________________
Children (#____)	____________________	___________	____________________

In addition to completing the above information, please check all that apply to family history:

- ☐ Cancer of Breast/Ovarian or Prostate
- ☐ Colon Cancer
- ☐ Diabetes or Hypertension
- ☐ Early Heart Attack (before age 55 for men and 65 for women)

SOCIAL

Occupation: _______________ Marital Status: ________ Living Will? …….. YES NO

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Name: ________________________ DOB: ________________________

Tobacco Use

- ☐ Never
- ☐ Former Use.... Year quit ________ # Years smoked ______ # Packs/day ______
- ☐ Current Use.... Age started ______ # Packs/day _________

Alcohol Use

Did you have a drink containing alcohol in the past year? .... YES NO

How often did you have a drink containing alcohol?

- ☐ Monthly or less
- ☐ 2 to 4 times a MONTH
- ☐ 2 to 3 times a WEEK
- ☐ 4 or more times a WEEK

How many alcoholic drinks did you have on a typical day?

☐ 1 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐ 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

PREVENTATIVE AND WELLNESS

Colonoscopy (month/year) _____________ Result: __________________________________

Eye exam (month/year) ______________ Result: __________________________________

Men only: Prostate blood test (month/year) __________

Women only: Bone density (month/year) __________ Gynecologist name ______________

Mammogram (month/year) _________ Result: _______________________

Pap smear (month/year) ____________ Result: _______________________

IMMUNIZATIONS

Tetanus (year) ________ Pneumovax (year) ______ Prevnar (year) ______

Hepatitis A (year) ________ Hepatitis B (year) ______ Chickenpox (year) ______

Shingles (year) ________ Gardasil/HPV (year) ______ Flu (month/year) ______

Fall Risk

Mobility Status (circle): Walking Walking with Assistance Wheelchair

Have you fallen in the past year (circle)? .... YES NO

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Mood Questions

Do you have little interest or pleasure in doing things?	YES	NO
Are you feeling down, depressed, or hopeless?	YES	NO

SPECIALIST PHYSICIANS that you see regularly (please list all)

____

____

____

Name of your previous PCP (including city/state): ________________________________

SYSTEM REVIEW - indicate if you have had any of the below symptoms in last <u>2 months</u>

Rate your pain on a scale (0 = no pain; 10 = debilitating pain) ______________

Excessive thirst or urination?	YES	NO
Significant headaches, slurred speech?	YES	NO
Double or blurred vision?	YES	NO
Diminished hearing or hoarseness?	YES	NO
Cough, shortness of breath, or wheezing?	YES	NO
Chest pain/pressure; rapid or irregular heartbeat?	YES	NO
Awakening at night short of breath?	YES	NO
Abnormal swelling in the legs or feet?	YES	NO
Pain or stiffness in your joints?	YES	NO
Abnormal nipple discharge or breast lump?	YES	NO
Skin rash, sore, or change of a mole?	YES	NO
Difficulty swallowing, heartburn, nausea, or vomiting?	YES	NO
Significant constipation or diarrhea; bloody or black bowel movements?	YES	NO
Do you feel you are at risk for sexually transmitted disease?	YES	NO
Weight loss of 10 pounds or more during the last 6 months?	YES	NO
Disruptive snoring?	YES	NO
Have others witnessed you stop breathing while sleeping?	YES	NO
Involuntary leakage of urinary?	YES	NO
Desire for hearing test?	YES	NO