Dr Mark H Levy

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PATIENT REGISTRATION FORM

Patient Name: _____

Social Security Number: _____ Date of Birth: _____/_____/_____

Sex: M / F (Circle one) Married/Single/Divorced/Widow (Circle one)

Occupation: _____

Address: _____

City_____ State_____ Zip code _____

Home Phone: (___) _____-_____ Cell Phone: (___) ____-_____

Email_____ Fax: (___) ____-_____

Join our email list. __Yes ___No
Associated Internal Medicine Physicians respects your privacy. We will not provide your email or any information about you to third parties.

Employer Name: _____
Employer Phone Number: (___) ____-_____

Address: _____

Referred By: _____

Reason for visit:_____

_____

Who to call for an emergency:

Name: _____ Phone: _____

Relationship: _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____

I.D. Number: _____ Group Number: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?
Y ____ N____ Claim #_____ Date of Injury_____

I authorize the release of any medical information necessary to process a claim with my insurance company, and permit the doctor to file for benefits on my behalf. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____Date: _____

Past Medical History

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Polio or Tuberculosis
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke or Heart Attack
- ☐ Thyroid Disorder

Past Surgical History

Surgery	Reason	Year	Hospitalized Y or N
_____	_____	_____	_____
_____	_____	_____	_____

Medications

Drug	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Health History

	Age	Health Status	If Deceased	Cause of Death
Mother	___	_____	_____	_____
Father	___	_____	_____	_____
Sisters	___	_____	_____	_____
Brother	___	_____	_____	_____

General
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Bleeding
- ☐ None

Eyes
- ☐ Pain
- ☐ Loss of Vision
- ☐ Double or blurred
- ☐ Dryness
- ☐ None

Ears/Nose/Mouth/Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ None

Kidney/Urine/Bladder
- ☐ Urgency
- ☐ Incontinence
- ☐ Retention
- ☐ Discharge from penis/vagina
- ☐ Prostate trouble
- ☐ None

Lymphatic
- ☐ Swollen Glands
- ☐ Tender Glands
- ☐ None

Endocrine
- ☐ Thyroid problems
- ☐ Other _____
- ☐ None

Mood
- ☐ Depression
- ☐ Anxiety
- ☐ None

Heart and Lungs
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Night sweats
- ☐ None

Stomach and Intestines
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach pain
- ☐ Yellow/Jaundice
- ☐ Constipation
- ☐ Persistent Diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn
- ☐ None

Skin
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitivity
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair Loss
- ☐ Color changes of hands or feet in the cold
- ☐ None

Muscle/Joint/Bones
- ☐ Morning stiffness
- ☐ Joint pain
- ☐ Muscle tenderness
- ☐ Other _____
- ☐ None

Sleep
- ☐ Do you sleep well?
- ☐ Do you wake feeling rested?
- ☐ Do you fall asleep during the day?
- ☐ Do you snore loudly?

Exercise
- ☐ Occasional
- ☐ Moderate
- ☐ High level
- ☐ None

Caffeine
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy
- ☐ None

Cups per day_____

Alcohol
- ☐ Occasional
- ☐ Moderate
- ☐ None

How often?
- ○ Less than 3 x week
- ○ More than 3 x week

How many drinks per week ? _____

Tobacco
- ☐ Currently using tobacco products
- ☐ Past use of tobacco products

Cigarettes _____ pks/day
Chew _____times/day
Cigars _____times/day
#of years _____
Year quit _____

Drugs
- ☐ Currently use recreational/street drugs
- ☐ Previously used recreational/street drugs

Please list_____
_____
_____