Lawrenceville Internal Medicine Associates, LLC
New Patient History Form

Name _____ Date of Birth _____

Date of first visit _____ Reason for visit _____

_____

Additional issues you would like to address _____

Past Medical History

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
□	□	High Blood Pressure	□	□	Asthma	□	□	Kidney Stones
□	□	High Cholesterol	□	□	Pneumonia	□	□	Urinary Infection
□	□	Heart Disease	□	□	Emphysema/COPD	□	□	Kidney Disease
□	□	Diabetes	□	□	Positive PPD	□	□	Arthritis
□	□	Blood Clot	□	□	Tuberculosis	□	□	Lupus
□	□	Stroke	□	□	Acid Reflux/GERD	□	□	Gout
□	□	TIA (Mini-stroke)	□	□	Stomach Ulcers	□	□	Psoriasis
□	□	Seizures	□	□	Gallstones	□	□	Osteoporosis
□	□	Headaches	□	□	Liver Disease	□	□	Thyroid Disorder
□	□	Migraine Headaches	□	□	Diverticulitis	□	□	Anemia
□	□	Depression	□	□	Hemorrhoids	□	□	Bleeding Disorder
□	□	Anxiety	□	□	Colon Polyps	□	□	Blood Transfusion
□	□	Hearing Loss	□	□	Enlarged Prostate	□	□	Neck Disorder
□	□	Glaucoma	□	□	Polycystic Ovaries	□	□	Back Disorder
□	□	Cataracts	□	□	Irregular Menses	□	□	Allergies
□	□	Macular Degeneration	□	□	Cancer _____			

Other Medical Conditions _____

_____

Medications

Please list all prescription and over the counter medications/supplements that you are taking

Name of medication	Dosage	How Often	Date started

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Allergies
Drug _____

Food _____

Environmental _____

Previous Surgeries & Hospitalizations (Please list date, reason, and hospital)
_____

_____

_____

_____

Habits
Do you ever use the following? If yes, how how often?
Tobacco _____

Alcohol _____

Recreational drugs _____

Caffeine _____

How often do you exercise?
Never 1-2 times/week 3-4 times/ week 5-6 times/per week Daily

Family History (Please also include any relatives with health problems)

Family Member	Living	Deceased	Age	Diseases
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Siblings				

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Health Screening (Please indicate if you have received the following screening tests & date performed)

Screening Test	Yes/No	Date/Results	Screening Test	Yes/No	Date/Results
Cholesterol			Colonoscopy		
Blood Pressure			Mammogram		
Blood Sugar			Pap Smear		
EKG			Prostate Test		
Bone Density			Tetanus		

Review of Systems (Please circle any symptoms you have experienced recently)

General	**Ears**	**Eyes**	**Nose**	**Throat**
Weight gain	Hearing loss	Vision loss	Nosebleed	Hoarseness
Weight loss	Ringing in ears	Blurry vision	Nasal congestion	Sore throat
Loss of appetite	Wax problem	Painful eyes	Snoring	Itchy throat
Night sweats	Ear pain	Redness	Post nasal drip	Difficulty swallowing
Weakness		Drainage	Decreased smell	Painful swallowing
Fatigue				
Swollen glands				
Cardiovascular	**Respiratory**	**Gastrointestinal**	**Urinary**	**Allergy**
Chest pain/tightness	Persistent cough	Nausea/Vomiting	Painful urination	Sinus congestion
Irregular heartbeat	Bloody sputum	Abdominal pain	Flank pain	Hives
Palpitations	Difficulty breathing	Heartburn	Nighttime urination	Itchy eyes
Swollen legs	Wheezing	Diarrhea	Urine leakage	Runny Nose
Painful legs	Painful breathing	Constipation	Difficulty urinating	
		Bloody stools	Frequent urination	
		Mucous in stools	Blood in urine	
		Rectal pain	Recurrent uti	
		Rectal bleeding		
Neuro	**Skin**	**Musculoskeletal**	**Hematologic**	**Psychiatric**
Headache	Rash	Joint pain	Easy bruising	Difficulties with sleep
Numbess/tingling	Itchy skin	Joint swelling	Varicose veins	Stress
Memory difficulties	Dry skin	Joint redness	Excessive bleeding	Feeling depressed
Speech problems	Change in moles	Joint stiffness		Feeling anxious
Tremors	New mole	Muscle pain		Changes in mood
Difficulty walking	Hair loss	Back pain		Changes in behavior
Lightheaded	Heat intolerance			Suicidal thoughts
Dizzy/vertigo	Cold Intolerance			Eating disorder
Fainting				Domestic abuse

For female patients	**For male patients**
Problems with fertility Abnormal discharge Menstrual History: Age of first period _____ Age of menopause _____ Frequency of menses _____Date of last menses _____ Pain during menses? Yes No Heavy bleeding? Yes No Bleeding between periods? Yes No Pregnancy History: Number of Pregnancies _____ Complications _____	Problems with fertility Abnormal discharge

LAWRENCENCEVILLE INTERNAL MEDICINE ASSOCIATES, LLC

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Lawrenceville Internal Medicine Associates, LLC to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company(ies) and/or physicians.

ASSIGNMENT OF BENEFITS & PAYMENT RESPONSIBILITY

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to Lawrenceville Internal Medicine Associates, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Lawrenceville Internal Medicine Associates' Notice of Privacy Practices.

ELIGIBILITY WAIVER

I understand that my eligibility for coverage may not be able to be confirmed at this time. I wish to receive medical service from Lawrenceville Internal Medicine Associates, LLC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

RELEASE OF RECORDS

Please complete this section with the names of any person, other than yourself, that you would like to have access to your medical information. If there are no names listed we will only be able to speak with you regarding your healthcare. Please consider if you want family members or friends to have any access to your health information.

I authorize the release of my medical information to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and agree to all statements, terms and conditions above.

Signature of Patient or Legal Guardian _____

Print Name _____ Date _____