Internal Medicine Physicians of Florida
Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Internal Medicine Physicians of Florida

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

Have you ever had any of the following Gastroenterological symptoms? (Please check all that apply)

- ☐ Abdominal Pain
- ☐ Anal Pain
- ☐ Bleeding (Black, Red, or Maroon Stool)
- ☐ Change in Appetite
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Excessive Gassiness
- ☐ Gluten Intolerance
- ☐ Heartburn/Acid Reflux
- ☐ Jaundice (Yellow Skin, Dark Urine)
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Pain when swallowing
- ☐ Vomiting
- ☐ Weight Gain
- ☐ Weight Loss

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Blood Disorder (including clots)
- ☐ Blood Transfusion
- ☐ Cancer Type: _____
- ☐ Celiac Disease
- ☐ Colon Cancer Polyps
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Depression
- ☐ Duodenal Ulcer
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Frequent Urinary Tract Infections
- ☐ Groin Hernia
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Mouth Ulcer
- ☐ Obesity Surgery
- ☐ Osteoporosis
- ☐ Parasites
- ☐ Pneumonia
- ☐ Sexually Transmitted Infection
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Other: _____

_____

Medications

What medications are you currently taking? (Include aspirin, blood thinners, vitamins, minerals, herbals, supplements, laxatives)

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

- ☐ ACE Inhibitors
- ☐ Adhesive Tape
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Fentanyl
- ☐ Iodine (including contrast dye)
- ☐ Latex
- ☐ Midazolam (Versed)
- ☐ NSAIDs (Ibuprofen, Naprosyn, Advil)
- ☐ Penicillin
- ☐ Seizure Medicines
- ☐ Sulfa
- ☐ Valium

Reactions: _____

_____

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Colon Polyps
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Rheumatism
- ☐ Thyroid Disorder
- ☐ None of the Above
- ☐ Not Sure

Details: _____

_____

Women Only

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Check if you have had any of the following:

- ☐ Endometriosis
- ☐ Ovarian Cyst(s)
- ☐ Menopause
- ☐ C/Section
- ☐ Tubal Ligation

Birth Control: ☐ Yes ☐ No If yes, type: _____

Hospitalizations & Surgeries

Reason	Date

Internal Medicine Physicians of Florida

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Previous Procedures

	Month & Year
☐ **CT Scan**	_____
☐ **Ultrasound/Sonogram**	_____
☐ **MRI**	_____
☐ **X-Ray**	_____
☐ **Upper Endoscopy**	_____
☐ **Colonoscopy**	_____
☐ **Biopsy**	_____

Immunizations

Please check and date all immunizations you have had.

	Month & Year
☐ Flu Vaccine	_____
☐ Hepatitis A	_____
☐ Hepatitis B (Series of 3)	_____
☐ Pneumovax	_____
☐ Rotavirus	_____
☐ Shingles (Zoster)	_____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for Sexually Transmitted Infections?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No What type? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Have you traveled or lived outside the US or Canada?

☐ Yes ☐ No

Review of Systems

General
- ☐ Cold Intolerance
- ☐ Fatigue
- ☐ Fevers

Eye
- ☐ Change in Vision
- ☐ Eye Pain

Mood
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Poor Sleep
- ☐ Suicidal Thoughts

Genitourinary
- ☐ Blood in Urine
- ☐ Change in Sexual Function
- ☐ Difficulty Urinating

Neurologic
- ☐ Headache
- ☐ Poor Balance
- ☐ Tingling in Hands/Feet

Heart and Circulation
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Swelling in Legs

ENT
- ☐ Changes in Voice
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Sore Throat

Muscles/Bones
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Skin
- ☐ Discoloration
- ☐ Hair Loss
- ☐ Hives
- ☐ Rash

Other Symptoms