PERSONAL INFORMATION

General

Last Name: _____First:_____ M.I.:_____ Preferred name: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Age: _____ Sex: _____ Race: ☐Hispanic,

☐ non-Hispanic, ☐ unknown Ethnicity: ☐ Black, ☐ White, ☐ Asian, ☐ Hispanic, other_____

Home Address: _____ Telephone: _____

Email Address: _____ Occupation: _____

Marital Status (Circle): Single/Married/Domestic Partner/Divorced/Widowed

Emergency contact:

Name: _____ Relationship_____ Phone number_____

Previous Physician (if applicable): _____Phone: _____

Primary Insurance

Insurance Company Name: _____ Group Number: _____

Policy Number_____ Address: _____

Insured's Date of Birth: _____/_____/_____ Insured's Name: _____

Relationship to Insured: _____

Authorization for Treatment

I authorize Dr Li Internal Medicine PA to perform procedures and treatment including administration of medicine and local anesthetics along with other medical procedures that may be medically necessary. I understand that this office will submit claims to the listed insurance company, but I am ultimately responsible for this account.
I also authorize the release of any medical information necessary to process my claim. To further provide continuity of care, I authorize the release of medical information to specialty as needed.

Patient/Legal Representative Signature: _____

Print name: _____ Date: _____

Pharmacy: _____---

HEALTH QUESTIONNAIRE

Patient Name: _____DOB: _____

Please indicate each of your chronic medical problems by marking the appropriate box below:

☐High Blood pressure	☐ Asthma	Please list any other medical problems
☐Heart Disease, what kind_____	☐ Emphysema/Lung disease	
☐ Diabetes	☐ Anemia	
☐ Cancer, what kind_____	☐ High Cholesterol	
☐ Thyroid, what kind_____	☐ Liver disease, what kind_____	
☐ Stroke	☐ Kidney Problem, what kind_____	

Please list all the medication that you are currently taking, strength (in milligrams) and how often.

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list them and the reaction they cause.

_____

Social history

Tobacco use: ☐ No ☐ Yes _____a day Number of years used: _____ Year Quit: _____
Alcohol use: ☐ No ☐ Yes _____drink per week Street Drugs: ☐ No ☐ Yes Specify:
Do you have a living will? ☐ Yes ☐ No

Family History: Please list any blood relative has suffered from cancer/chronic diseases/mental diseases.

Cancer/Diseases	Relationship	Cancer/Diseases	Relationship	Cancer/Diseases	Relationship

Please list any surgeries (including the year):

Are you under the care of any other doctor for any medical problems? If so, whom and for what medical problem?

Year of last: Tetanus Shot_____ Flu Shot_____ Pneumonia Vaccine_____

Women only:
Date of Last: Mammogram_____ (Abnormal? _____) PAP_____ (Abnormal? _____)

Osteoporosis Scan_____ Have you been a victim of abuse? ☐ Yes ☐ No

Have you ever had sigmoidoscopy or colonoscopy? ☐ Yes ☐ No

If yes, which year? _____ Ordering doctor's name_____

Phone number_____

Current illness: Do you have any of the following currently?

☐ Fever/Chills	☐ Night sweat	☐ Unexpected weight loss	☐ Leg/arm weakness	☐ Other complains
☐ Shortness of breath	☐ Chest pain	☐ Nausea	☐ New bony pain	
☐ vomiting	☐ Diarrhea	☐ Constipation		

Patient/Legal Representative signature_____

Date: _____