Registration Form (Please Print)

Date _____ - Patient Information - Home Phone_____

Name _____ Soc Sec # _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's Employer _____ Occupation _____

Business Address _____ Wk Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____ _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Address _____ City _____ State _____ Zip_____
(If different than patient)

Person Responsible Employed by _____ Occupation _____

Business Address _____ Wk Phone _____

Insurance Co _____ Group # _____ Member # _____

Additional Insurance

Is patient covered by additional insurance? ☐ YES ☐ NO Subscriber Name_____

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Address _____ City _____ State _____ Zip_____
(If different than patient)

Subscriber Employed by _____ Wk Phone _____

Insurance Co _____ Group # _____ Member # _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company (ies)

and assign directly to Manassas Internal Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Manassas Internal Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Manassas Internal Medicine

Privacy Disclosure Form

Client Name:

_____

Manassas Internal Medicine (MIM) respects your right to privacy. You, as a client, have the right to make certain choices about the uses and disclosures of your health information. Any information you authorize for use and disclosure may be re-disclosed and is no longer protected. You may amend your elections for restrictions by contacting the Privacy Officer.

- I authorize and consent to the release of my health information to the following individuals:

_____ _____ _____

Name of Person or Persons

- I would like to receive all written communications at the following location rather than my home address (if none specified, written communications will be forwarded to your home address):

_____

P.O. Box or Street Address, City, State, Zip

I would like to receive appointment reminders and patient care follow-up communications only by the following means (*check all that apply*):

- ☐ Mail
- ☐ Home Phone ( ) _____
- ☐ Work Phone ( ) _____
- ☐ Cell Phone ( ) _____

NOTE: Manassas Internal Medicine reserves the right to implement stricter privacy standards under certain circumstances which it deems necessary for the protection of the patient.

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I acknowledge that I have been given the Manassas Internal Medicine NOTICE OF PRIVACY PRACTICES and have had the opportunity to ask questions about the information provided in the notice. I understand that I have the right to request other reasonable requests regarding confidential communications by contacting the Privacy Officer as specified in the NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship

Effective 4/14/2003

MANASSAS INTERNAL MEDICINE
9303 FOREST POINT CIRCLE
MANASSAS,VA. 20110
703-257-7749

DATE:_____/_____/_____

NAME:_____
DATE OF BIRTH:_____/_____/_____
SEX:_____

A-REASON FOR VISIT

_____
_____
_____

HISTORY QUESTIONNAIRE

B- PATIENT PROFILE

-Martial status:_____ -Hobbies:_____
-Occupation:_____ -Last physical exam:_____
Since:_____ Retired? Y N

C- HEALTH OF FAMILY

Please indicate the status of each family member by writing good, poor, or deceased by their name. If deceased, note age and cause (include fatal accidents and suicides.)

-Father (natural/biological):_____
-Mother (natural/biological):_____
-Siblings:_____
_____
_____
-Spouse:_____
-Children:_____

D-IMMUNIZATIONS

Circle those that you have had and enter the year of the most recent if known.

Flu_____ Tetanus_____ Pneumonia_____

E-ILLNESS

Please indicate if you have had any of the following by placing an "S" for self by the illness. If a blood relative has had any of the following, please place a "B" by the corresponding illness.

_____Alcoholism
_____Anemia
_____Bleed easily
_____Diabetes
_____Drug abuse
_____Depression
_____Eczema, hives, rashes
_____Liver disease, hepatitis, yellow jaundice
_____Lung disease
_____Epilepsy, seizures
_____Glaucoma
_____Heart disease
_____Stroke
_____Suicide attempt
_____Eye problems
_____Phlebitis
_____Thyroid disease
_____Venereal disease
_____Cancer, tumor
_____High blood pressure
_____Ulcer in stomache or duodenum
_____Nervous breakdown
_____Mumps,measles, chicken pox
_____Rubella, German measles
_____Rheumatic fever

F- HOSPITALIZATIONS/SURGERY

List illness or operationand approximate year. Exclude all normal pregnancies.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

G- MEDICINES

List all medications, birth control pills, or vitamins you take with or without a prescription and doses if known.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

H- MEDICINE ALLERGIES

List all medications that you are allergic to:

_____
_____
_____

I- Please check all that apply to you:

ever smoke_____	use seatbelts_____
ever drink alcohol_____	practice safe sex____
ever use drugs_____	have a living will_____
ever drink coffee_____	

J- Please circle "Y" for yes or "N" for no in response to the following questions.

1. Do you have any skin problems?……	Y	N
2. Does your skin itch or burn?……..	Y	N
3. Do you have trouble stopping even a small cut from bleeding?…	Y	N
4. Do you bruise easily?……..	Y	N
5. Do you ever faint or feel faint?……..	Y	N
6. Is any part of your body always numb?……	Y	N
7. Have you ever had seizures or convulsions?……	Y	N
8. Has your handwriting changed lately?……	Y	N
9. Do you have a tendency to shake or tremble?……	Y	N
10. Are you very nervous around strangers?……	Y	N
11. Do you find it hard to make decisions?……	Y	N
12. Do you find it hard to concentrate or remember?……	Y	N
13. Do you usually feel lonely or depressed?……..	Y	N
14. Do you often cry?……..	Y	N
15. Would you say you have a hopeless outlook?……	Y	N
16. Are you having any sexual difficulties?……..	Y	N
17. Have you ever considered committing suicide?……	Y	N
18. Have you ever desired or sought psychiatric help?……..	Y	N
19. Have you gained or lost much weight recently?……	Y	N
20. Do you have a tendency to be too hot or too cold?……	Y	N
21. Have y ou lost interest in eating lately?	Y	N
22. Do you always seem to be hungry?……	Y	N
23. Are you more thirsty than usual lately?……	Y	N
24. Are there any swellings in your armpits or groin?……	Y	N
25. Do you seem to feel exhausted or fatigued most of the time?…	Y	N

26. Do you have difficulty falling asleep or staying asleep?…….. Y N
27. Do you exercise more than 3 times a week?…… N Y
28. How much do you smoke per day?…….
I don't smoke_____
cigerettes_____
cigars_____

29. List any country outside the USA you have visited in the past 6 months.
_____

30. Are you troubled by heartburn?……. Y N
31. Do you feel bloated after eating?……. Y N
32. Are you troubled by belching?…… Y N
33. Do you suffer discomfort in the pit of your stomach?……. Y N
34. Do you become nauseated easily?……..…… Y N
35. Have you ever vomitted blood?……. Y N
36. Is it difficult or painful for you to swallow?…….. Y N
37. Have your bowel movements changed recently?…….. Y N
38. Have you had any bleeding from your rectum?……. Y N

39. Do you frequently get up at night to urinate?……. Y N
40. Do you urinate mo re than five or six times a day……. Y N
41. Do you wet your pants or your bed?…….. Y N
42. Have you ever had burning or pains when you urinate?…….. Y N
43. Has your urine ever been brown, black, or bloody?…….. Y N
44. Do you have difficulty starting your urine flow?…… Y N
45. Do you have a constant feeling that you have to urinate?…….. Y N

BOTH MEN AND WOMEN

46. Are you troulbled with stiff or painful muscles or joints?..... Y N
47. Are your joints ever swollen?……. Y N
48. Do you have back or shoulder pain?…….. Y N
49. Are your feet often painful?…….. Y N
50. Are you handicapped in any way?…….. Y N
51. Do you have headaches more than once a week?…….. Y N
52. Does twisting your neck quickly cause pain?…….. Y N
53. Have you ever had lumps or swelling in your neck?…… Y N

54. Do you wear glasses/contact lenses…… Y N
55. Have you ever had cataracts?…….. Y N
56. Have you had any trouble with your eyes in the last 2 years?… Y N
57. Do you have any difficulty hearing?……. Y N
58. Do you get motion sickness in cars or on planes?…….. Y N
59. Do you have any problems with your teeth?……. Y N
60. Have your taste senses changed lately?……. Y N

61. Does your nose stuff up or run when you don't have a cold?.... Y N
62. Do you ever have head colds 2 or more months in a row?……. Y N
63. Does your nose ever bleed for no reason at all?…….. Y N
64. Is your throat ever sore when yu don't have a cold?..... Y N
65. Have you ever been told that your tonsils were enlarged?…….. Y N

66. Has your voice ever been hoarse without a cold?…….. Y N
67. Do you wheeze or have to gasp when you breathe?…… Y N
68. Are you bothered by coughing spells?…….. Y N
69. Do you cough up a lot of phlegm?…… Y N
70. Have you ever coughed up blood?…….. Y N
71. Do you get more than 1 chest cold a month?…….. Y N
72. Are you sweating a lot or wake up with night sweats?…… Y N
73. Have you ever been told that you had high blood pressure?….. Y N
74. Have you been bothered by a thumping or racing heart?……. Y N
75. Do you ever have pain or tightness in your chest?…….. Y N
76. Do you have trouble with dizziness or lightheadedness?……. Y N
77. Does little effort leave you short of breath?…… Y N
78. Do you wake up at night short of breath?…… Y N
79. Do you have trouble with swollen feet or ankles?..... Y N
80. Do you get cramps in your legs at night or upon walking?….. Y N
81. Have you ever been told that you have a heart murmur?..... Y N
82. Do you snore at night?…… Y N
83. Do you wake up still tired?…… Y N
84. Do you feel a need to sleep frequently during the day?……. Y N
85. Do you fall asleep quickly at night?..... Y N
86. Do you grind your teeth while sleeping?…….. Y N
87. Does your bed partner complain that you kick alot while sleeping?…….. Y N

FOR MEN ONLY

88. Is your urine very weak or slow?…… Y N
89. Has a doctor ever told you that you have prostate trouble?…… Y N
90. Have you had any burning or discharge from your penis?…….. Y N
91. Are there any swellings or lumps in your testicles?…… Y N
92. Do your testicles get painful?…….. Y N
93. Do you have difficulty getting or maintaining an erection?…….. Y N

FOR WOMEN ONLY

94. What was the date of your last menstual period?…… Y N
95. Are you past your menopause or had a hysterectomy?……. Y N
If yes, have you noticed any bleeding since?…… Y N
(please skip to question 97)
96. Was your last period normal?…….. Y N
97. Do you have heavy bleeding with your periods?…… Y N
98. Do you bleed between periods?…….. Y N
99. Do you bleed after intercourse?…….. Y N
100. Have you had any recent vaginal itching or discharge?..... Y N
101. Do you examine your breasts monthly?…… Y N
102. Have you ever noticed any lumps or pain in your breasts?……. Y N
103. Have you ever had any complications with birth control?……. Y N
104. Do you have any sexual difficulties?…… Y N
105. Write the date and month of your last PAP test. _____
106. # of pregnancies_____ 107. # of children born alive_____
108. # of premature births_____ 109. # of miscarraiges_____
110. # of stillbirths_____