

Welcome To Thunderbird Internal Medicine

Patient Name: _____ **Appointment Date:** _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Patient **Home** Phone: _____ **Cell** Phone: _____

Date of Birth: _____ Social Security #: _____

Email address: _____

Would you like to receive our E-mail newsletter? Yes No

Are YOU currently employed? Full Time Part Time Student Retired Disabled

Employer: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

****Do you have insurance through YOUR employer? Yes No**

Spouse's Name: _____ **Spouse's Date of Birth:** _____

Spouse Employer: _____ **Is Spouse Retired?** Yes No

Is your spouse the policy holder of your primary insurance? Yes No

Primary Insurance: _____

Policyholder Name: _____ Relationship to patient: _____

Policyholder date of birth: _____ Employer: _____

Group #: _____ Policy/ID #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Policyholder Name: _____ Relationship to patient: _____

Policyholder date of birth: _____ Employer: _____

Group #: _____ Policy/ID #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

****Do you have AHCCCS or Tertiary(3rd) Insurance?** Yes No

If yes, Plan Name/ID#: _____

Emergency Contact Name (not living with you): _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms within this office. If my account is referred for collection, I agree to pay reasonable collection expenses including attorney's fees.

In the event that I am entitled to health insurance or other benefits relating to my medical condition and it is available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill.

This office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical bills/charges.

Patient/Parent/Guardian Signature:

Date: _____

Thunderbird Internal Medicine

5620 W. Thunderbird Suite F-1

Name _____

Date _____ Chart# _____ Age _____

Past Medical History

<input type="checkbox"/> Heart Attack/Disease	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Deep Venous Thrombosis (DVT)	<input type="checkbox"/> Kidney Stones/Problems	<input type="checkbox"/> Gout	
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Valley Fever	For Office Use Only
<input type="checkbox"/> Tuberculosis/(+)Skin test	<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Degenerative Arthritis	<input type="checkbox"/> Allergies	HT _____
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Peptic Ulcer	Wt _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis/Liver Problem	<input type="checkbox"/> Diabetes	BP _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke	HR _____
<input type="checkbox"/> Menopause/ERT ()	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Osteoporosis	Temp _____
	<input type="checkbox"/> Migraine	<input type="checkbox"/> Other _____	Plan _____

Past Surgical History

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gallbladder	
<input type="checkbox"/> Knee/Shoulder/Hip Surgery	<input type="checkbox"/> Thyroid Surgery	<input type="checkbox"/> Hysterectomy/BSO	
<input type="checkbox"/> Breast Surgery/biopsy	<input type="checkbox"/> Prostate Surgery	<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Cataract R () L ()	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> C-section	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Medications

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (reaction)

Immunizations

<input type="checkbox"/> Tetanus (19__)	<input type="checkbox"/> Influenza (within last year)	<input type="checkbox"/> Hepatitis B (19__)
<input type="checkbox"/> Pneumovax(19__)	<input type="checkbox"/> Chicken Pox Vaccine	<input type="checkbox"/> Other _____

Social History

Occupation _____ Marital Status: Single () Married () Widowed () Divorced ()

Tobacco Now () Never () In the Past () Amount per day _____ Year quit _____ Age Started _____

Alcohol Never () Rare () Occasional () Moderate () Heavy () Amount/type per day _____

Family History

	Major Medical Problems	Age of Death	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers #__	_____	_____	_____
Sisters #__	_____	_____	_____
Children #__	_____	_____	_____

Family History of: Breast Cancer (); Colon Cancer (); Diabetes (); High Blood Pressure (); Early Heart attack ()

Preventative Medicine

Last Pap (month/year) _____/_____/_____ Last Mammogram _____/_____/_____ Last Protoscopic Exam _____/_____/_____

Systems Review

Patient Name _____ Date _____

Indicate by checking "yes" or "no" to any symptoms you have had in **recent** months. **Circle** the symptoms you have had when multiple symptoms are listed.

	No	Yes	Medical Team use only
1. Skin rash, sore, excessive bruising or change of a mole?	___	___	_____
2. Excessive thirst or urination?	___	___	_____
3. Change in sexual drive or performance?	___	___	_____
4. <u>Significant headaches, slurred speech, difficulty moving/numbness in an arm or leg?</u>	___	___	_____
5. Eye problems such as double or blurred vision, cataracts or glaucoma?	___	___	_____
6. Diminished hearing, dizziness, hoarseness or sinus problem?	___	___	_____
7. Nosebleeds, ringing in the ears?	___	___	_____
8. <u>Cough, shortness of breath, wheezing or asthma?</u>	___	___	_____
9. Coughing up sputum or blood?	___	___	_____
10. Exposed to anyone with tuberculosis?	___	___	_____
11. "Blacked out", lost consciousness or had a seizure?	___	___	_____
12. <u>Chest pain/pressure, rapid or irregular heart beats, heart valve problems?</u>	___	___	_____
13. Awakening at night short of breath?	___	___	_____
14. Abnormal swelling in the legs or feet?	___	___	_____
15. Pain in the calves of your legs when you walk?	___	___	_____
16. <u>Difficulty swallowing, heartburn, nausea, vomiting, bloating or stomach trouble?</u>	___	___	_____
17. Significant constipation/diarrhea; blood or changes in bowel movements?	___	___	_____
18. Past history of yellow jaundice or colon polyps?	___	___	_____
19. Difficulty starting urination, emptying bladder or involuntarily losing urine?	___	___	_____
20. <u>Burning, pain or blood when urinating?</u>	___	___	_____
21. Pain, stiffness or swelling in your back, joints or muscles?	___	___	_____
22. Hot flashes or night sweats?	___	___	_____
23. Enlarged glands (lymph nodes)?	___	___	_____
24. <u>Do you feel you are at risk for HIV or AIDS?</u>	___	___	_____
25. History of anemia, elevated cholesterol or blood sugar?	___	___	_____
26. Experiencing a stressful situation or depressed mood?	___	___	_____
27. Weight gain/loss of 10 pounds during the last 6 months?	___	___	_____
28. <u>Problems falling asleep, sleep apnea or disruptive snoring?</u>	___	___	_____
29. Abnormal nipple discharge or breast lump?	___	___	_____
30. Have you felt a need to cut down on alcohol consumption?	___	___	_____
31. Do relatives/friends worry or complain about your alcohol consumption?	___	___	_____
32. <u>Have you been physically, sexually or emotionally abused?</u>	___	___	_____
<u>For Female patients only</u>			
33. Have you ever had an abnormal Pap smear?	___	___	_____
34. Have you experienced menopause or had a hysterectomy?	___	___	_____
If "no": Are you concerned about your periods?	___	___	_____
Might you be pregnant at this time?	___	___	_____
Date of onset of your last period _____			
35. Number of: Pregnancies _____ Live births _____ Miscarriages/Abortions _____	___	___	_____