NAME:_____ DOB:_____ DATE: _____

NOVI INTERNAL MEDICINE & PEDIATRICS Thank you for choosing our practice!

Please let us know the main reason for your visit today:

PAST MEDICAL HISTORY: (please check off ANY conditions you have been diagnosed with or list below)

❑ Hypertension	❑ Thyroid Disease	❑ Arrhythmia	❑ Heart Disease
❑ Diabetes	❑ Asthma	❑ Stroke	❑ Arthritis
❑ High Cholesterol	❑ Osteoporosis	❑ Cancer (type):	❑ Kidney Disease

OTHER CONDITIONS LIST HERE:

PAST SURGICAL HISTORY:

SURGERY:	DATE:	SURGERY:	DATE:

CURRENT MEDICATIONS:. Include non-prescription meds & vitamins/ supplements: (use back if needed)

Name of drug	Dose (strength and frequency)	Name of drug	Dose (strength and frequency)
1.		5.	
2.		6.	
3.		7.	
4.		8.	

MEDICATION ALLERGIES: Please list any medications that you are allergic to and the reaction

Name of drug:	Reaction:	Name of drug:	Reaction:
1.		4.	
2.		5.	
3.		6.	

OTHER ALLERGIES: Medications/Environmental/Food:

Allergen:	Reaction:	Allergen	Reaction:
1.		4.	
2.		5.	

NAME:_____ DOB:_____ DATE: _____

SOCIAL HISTORY
MARITAL STATUS: _____SINGLE ____MARRIED _____DIVORCED _____WIDOWED _____SIG OTHER/PARTNER
# of CHILDREN:
OCCUPATION: ❑ Employed (Occupation):_____ ❑ Unemployed ❑ Stay at home parent ❑ Retired ❑ Disabled
EDUCATION (last grade completed in school): _____

Smoking History:	❑ Non-Smoker	❑ Current Smoker Packs/day: # Years:	❑ Former smoker Quit Date:
Alcohol Use:	❑ Non-drinker	❑ # drinks/week:	❑ Daily Drinker
Drug Use:	❑ None	❑ Current Use: type:	❑ Former Drug Use: type:

FAMILY HISTORY:

Family Member	Medical Conditions	Deceased ?
Children (include name & DOB)		
1.		
2.		
3.		
Mother		
Father		
Sibling 1 : __BROTHER ___SISTER		
Sibling 2 : __BROTHER ___SISTER		
Grandmother		
Grandfather		
OTHER RELEVANT HISTORY		

OTHER PROVIDERS: please list any specialists you see **REGULARLY** here

SPECIALIST NAME	FIELD (Cardiology, Gyne etc.)	REASON

DOS_____ Last Name _____ First Name _____ DOB_____

REVIEW OF SYSTEMS

Instructions: Check the box for each symptom that you have now or have had in the past three months. Fill in the blank spaces.

General:
- ☐ weakness
- ☐ fatigue
- ☐ chills
- ☐ night sweats
- ☐ change in weight, appetite or sleeping habits

Eyes:
- ☐ glasses or contacts
- ☐ blank spots in your field of vision
- ☐ excessive tearing or discharge
- ☐ eye pain
- ☐ double vision
- ☐ last eye exam, date: _____

Ears, Nose, Sinuses, Mouth and Throat:
- ☐ loss or trouble hearing
- ☐ ringing
- ☐ drainage
- ☐ frequent earaches
- ☐ nosebleed
- ☐ post nasal drip
- ☐ blockage of nose
- ☐ sinus pain
- ☐ sore throat
- ☐ hoarseness
- ☐ dentures
- ☐ bleeding gums
- ☐ toothache
- ☐ last dental exam, date:_____

Lungs:
- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ spitting up blood
- ☐ positive TB test
- ☐ last chest X-ray, date: _____

Heart:
- ☐ chest pain
- ☐ palpitations (heart pounding)
- ☐ trouble breathing at night
- ☐ fatigue easily with exercise
- ☐ ankle swelling

Skin:
- ☐ itching
- ☐ rash
- ☐ change in color
- ☐ changes in warts, moles, or birthmarks

Breast:
- ☐ lumps in breast
- ☐ discharge from nipple
- ☐ last mammogram, date: _____

Gastrointestinal:
- ☐ vomiting
- ☐ difficulty swallowing
- ☐ stomach or abdominal pain
- ☐ indigestion or heartburn
- ☐ ulcers
- ☐ changes in bowel habits
- ☐ blood in stools (or black stools)
- ☐ hemorrhoids
- ☐ sigmoid or colonoscopy, date: _____

Musculoskeletal:
- ☐ pain
- ☐ stiffness
- ☐ weakness
- ☐ twitching
- ☐ deformity
- ☐ chronic back pain
- ☐ joint swelling
- ☐ decreased range of motion

Vaginal and Urinary (female):
- ☐ vaginal itching or burning
- ☐ vaginal discharge
- ☐ sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- ☐ sexual difficulties
- ☐ last menstrual period, date: _____
- ☐ problems with menstrual periods
- ☐ last pap smear, date: _____
- ☐ methods of contraception: _____
- ☐ pregnancy, number: _____
- ☐ problems during pregnancy
- ☐ miscarriages or abortions, number: _____
- ☐ pain or frequent urination
- ☐ previous urinary infections
- ☐ blood in urine
- ☐ kidney stones
- ☐ trouble starting stream
- ☐ incontinence (leaking)

Genitals and Urinary (male):
- ☐ hernia
- ☐ discharge from penis
- ☐ pain or lump in testicles
- ☐ methods of contraception: _____
- ☐ sexual difficulties
- ☐ sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- ☐ pain or frequent urination
- ☐ previous urinary infections
- ☐ blood in urine
- ☐ kidney stones
- ☐ trouble starting stream
- ☐ incontinence (leaking)

Hematologic and Lymphatic:
- ☐ easy bruising or bleeding problems
- ☐ swollen lymph nodes

Endocrine:
- ☐ excessively hot
- ☐ always thirsty
- ☐ excessively cold
- ☐ always hungry

Nervous System:
- ☐ headaches
- ☐ numbness
- ☐ head injury
- ☐ seizures
- ☐ dizziness or passing out
- ☐ loss of coordination or balance

Psychological:
- ☐ nervousness or anxiety
- ☐ depression
- ☐ unable to sleep
- ☐ nightmares
- ☐ memory loss

NOVI INTERNAL MEDICINE AND PEDIATRICS, PLLC
37475 Lewis Dr
Suite 130
Novi, MI 48377

When Your Doctor Needs To Contact You, But You Are Not Available

OAI

Other Authorized Individual

Patient Name: _____ **DOB**: _____

As required by HIPPA (Health Information Portability and Accountability Act) you have a right to nominate one or more persons to act on your behalf of receiving information with respect to your health information that pertains to you. By completing this form you are informing us of your wish to designate the name or names of individuals and telephone numbers where we can leave detailed information about your health care concerns. These individuals can be your spouse, family member or friend. By completing this form you are informing us of your wish to designate the named person as your **personal representative**.

Authorization Section

I designate the following person(s) to receive information about my health care and act as a personal representative with the use and/or disclosure of health information pertaining to me.

1) _____
Print Last name First Name Phone # Relationship

- ____ Can pick up controlled prescriptions
- ____ All medical information
- ____ Just Emergency Contact
- ____ Other_____

2) _____
Print Last name First Name Phone # Relationship

- ____ Can pick up controlled prescriptions
- ____ All medical information
- ____ Just Emergency Contact
- ____ Other_____

Signature: _____ **Date**: _____