INTERNAL MEDICINE AND WELLNESS CENTER

Dr. Ronald Bush
44-300 Monterey Ave Ste:B
Palm Desert, Ca 92260
T: 760-200-2992
F: 760-200-2993

Patient Intake Form

Patient Information

Name:_____S.S#_____
Address:_____
_____
City:_____State:_____Zip:_____
Sex:[__]M [__]F Age:_____Birth Date:_____
Marital Status: [ ]Single[ ]Married[ ]Widowed[ ]Separated[ ]Divorced Patient
Employed By:_____
Occupation:_____
Home Phone:_____ Work/Mobil Phone:_____
Email Address:_____
In case of emergency, who should we notified?_____
Phone Number:_____
Whom may we thank for referring you?_____
Phone Number:_____

Primary Insurance

If same as above, you may skip this part.

Insurance Name:_____
Person Responsible For Account:_____
Relation To Patient:_____
D.O.B:_____S.S#:_____
Phone Number:_____Cell/Work:_____
Address (if different from patient):_____
_____
City:_____State:_____Zip:_____
Person Responsible Employed By:_____
Occupation:_____
Business Address_____
Insurance Company:_____

Additional Insurance

Insurance Name:_____
Person Responsible For Account:_____
Relation To Patient:_____
D.O.B:_____S.S#:_____
Phone Number:_____Cell/Work:_____
Address (if different from patient):_____
_____
City:_____State:_____Zip:_____
Person Responsible Employed By:_____
Occupation:_____
Business Address_____
Insurance Company:_____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with
_____
and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions

_____ _____ _____
Responsible Party Signature Relationship Date

Health History Questionnaire

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Name:_____

[__]Male [__]Female DOB:_____

[__]Single [__]Partnered [__]Married [__]Separated [__]Divorced [__]Widowed

Previous Referring Dr:_____Date Of Last Exam:_____

Personal History

Childhood Illness:

[__]Measles [__]Mumps [__]Rubella [__]Chickenpox [__]Polio [__]Rheumatic Fever

Immunizations and Dates:

[__]Tetanus_____[__] Pneumonia_____

[__] Hepatitis_____ [__] Chickenpox_____

[__] Influenza _____[__] Measles_____

[__]Mumps_____[__]Rubella_____

List Any Medical Problems That Other Doctors Have Diagnosed:_____

_____

_____

_____

_____

_____

_____

_____

Surgeries:

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? [__]Yes [__]No
Date of Transfusion:_____
Location:_____

Women Only

Age at onset menstruation?	
Date of last menstruation?	
Period every _____ days	
Heavy Periods, Irregular, Spotting, Pain, Discharge?	[__]Y [__]N
Number or Pregnancies_____ Number or live births_____	
Are you pregnant or breastfeeding?	[__]Y [__]N
Have you had a D&C, Hysterectomy, or Cesarean?	[__]Y [__]N
Any urinary tract, bladder, or kidney infections within the last year?	[__]Y [__]N
Any blood in your urine?	[__]Y [__]N
Any hot flashes or sweating at night?	[__]Y [__]N
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the period?	[__]Y[__]N
Experienced any recent breast tenderness, lumps, or nippledischarge?	[__]Y [__]N
Date of last pap and rectal exam	[__]Y [__]N
Any problems with control of urination?	[__]Y [__]N

Men Only

Do you usually get up to urinate during the night	[__]Y[__]N
If yes, How many times?	
Do you feel pain or burning with urination?	[__]Y[__]N
Any blood in your urine?	[__]Y[__]N
Do you feel burning discharge from penis?	[__]Y[__]N
Has the force of your urination decreased?	[__]Y[__]N
Have you had any kidney, bladder, or prostate infections within the last 12 months?	[__]Y[__]N
Do you have any problems emptying your bladder completely?	[__]Y[__]N
Any difficulty with erections or ejaculation?	[__]Y[__]N
Any testicle pain or swelling?	[__]Y[__]N
Date of last prostate and rectal exam?	

Other Problems

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain

[__]Skin	[__]Chest/Heart	[__]Recent changes in:
[__]Head/Neck	[__]Back	[__]Weight
[__]Ears	[__]Intestinal	[__]Energy Level
[__]Nose	[__]Bladder	[__]Ability to sleep
[__]Throat	[__]Bowel	[__]Other pain/Discomfort
[__]Lungs	[__]Circulation	

Sexual History

Are you sexually active?	[__]Y[__]N
If yes, are you trying for a pregnancy?	[__]Y [__]N
If not trying for a pregnancy, list contraceptive or barrier method used:	
Any discomfort with intercourse?	[__]Y [__]N
Illness related to the Human Immunodeficiency Virus (HIV), such asAIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	[__]Y [__]N
Do you live alone?	[__]Y [__]N
Do you have frequent falls?	[__]Y [__]N
Do you have vision or hearing loss?	[__]Y[__]N
Do you have an Advance Directive or Living Will?	[__]Y[__]N
Would you like information on the preparation of these?	[__]Y[__]N
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	[__]Y [__]N

Family History

	Age	Significant Health Problems
Father		
Mother		
Siblings	[_]M [_]F	
	[_]M [_]F	
	[_]M [_]F	
	[_]M [_]F	
	[_]M [_]F	
	[_]M [_]F	
Children	[_]M [_]F	
	[_]M [_]F	
	[_]M [_]F	
	[_]M [_]F	
Grandmother (Maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		

Mental Health

Is stress a major problem for you?	[__]Yes [__]No
Do you feel depressed?	[__]Yes [__]No
Do you panic when stressed?	[__]Yes [__]No
Do you have problems with eating or your appetite?	[__]Yes [__]No
Do you cry frequently?	[__]Yes [__]No
Have you ever attempted suicide?	[__]Yes [__]No
Have you ever seriously thought about hurting yourself?	[__]Yes [__]No
Do you have trouble sleeping?	[__]Yes [__]No
Have you ever been to a counselor?	[__]Yes [__]No

List your prescribed and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency

Allergies

Drugs Allergic to	Reactions

Health & Personal Safety

Exercise	[__] Sedentary (no exercise)			
	[__] Mild Exercise (I.e, climb stairs, walk 3 blocks, golf)			
	[__] Occasional Vigorous Exercise (I.e, work or recreation, less than 4x/week for 30 mins)			
	[__] Regular Vigorous exercise (I.e, work or recreation 4x/week for 30 mins			
Diet	Are you dieting?			[__]Yes[__]No
	If yes, are you on a physician prescribed medical diet?			[__]Yes[__]No
	# of meals you eat in an average day?			
	Rank salt intake	[__] High	[__] Med	[__] Low
	Rank fat intake	[__] High	[__] Med	[__] Low
Caffeine	[__] None	[__] Coffee	[__] Tea	[__] Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			[__]Y [__]N
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			[__]Y [__]N
	Have you considered stopping?			[__]Y [__]N
	Have you ever experienced blackouts?			[__]Y [__]N
	Are you prone to “binge” drinking?			[__]Y [__]N
	Do you drive after drinking?			[__]Y [__]N
Tobacco	Do you use tobacco?			[__]Y [__]N
	[__] Cigarets	[__] Chew-	[__] Pipe #__	[__]Cigars-#__

	[__] # of years	[__] or years quit	
Drugs	Do you currently use recreational or street drugs?		[__]Y[__]N
	Have you ever given yourself street drugs with a needle?		[__]Y [__]N

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Acknowledgment of Receipt of Privacy Practices

I have received a copy of the "Notice Of Privacy Practices". The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (760) 200-2992 or by requesting the Notice in person at: Ronald Bush MD at 44-300 Monterey Ave St B, Palm Desert CA

_____ _____

Signature Date

_____

Print Name

As the representative of the above individual, I acknowledge recipient of the Notice on his or her behalf.

_____ _____

Signature Date

_____ _____

Print Name Relationship To Patient

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Acknowledgment

Patients Name:_____
DOB:_____Telephone:_____
Address:_____
City_____State:_____Zip_____

This acknowledges that the physician, or his staff members, have provided me with information concerning Advance Directives.

1. I am age 18 or older. Yes No
2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me with written information concerning the Advance Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.
3. I am aware that Advanced Directives may be any one of the following: a. A durable power of Attorney For Health Care.
   b. The declaration in the A Natural Death Act-Ex. A Living Will
   c. I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

Patient Signature:_____Date:_____