

**Dr Mark H Levy**

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**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: M / F (Circle one) Married/Single/Divorced/Widow (Circle one)

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Email \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Join our email list.  Yes  No

Associated Internal Medicine Physicians respects your privacy. We will not provide your email or any information about you to third parties.

Employer Name: \_\_\_\_\_

Employer Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

\_\_\_\_\_

**Who to call for an emergency:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Plan Name: \_\_\_\_\_

I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?

Y \_\_\_\_ N \_\_\_\_ Claim # \_\_\_\_\_ Date of Injury \_\_\_\_\_

I authorize the release of any medical information necessary to process a claim with my insurance company, and permit the doctor to file for benefits on my behalf. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Past Medical History

Please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety Disorder                | <input type="checkbox"/> HIV or AIDS            |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> High Cholesterol       |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Bleeding Disorder               | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Blood Clots (or DVT)            | <input type="checkbox"/> Kidney Stones          |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Leg/Foot Ulcers        |
| <input type="checkbox"/> Coronary Artery Disease         | <input type="checkbox"/> Liver Disease          |
| <input type="checkbox"/> Claustrophobic                  | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Pacemaker              |
| <input type="checkbox"/> Dialysis                        | <input type="checkbox"/> Polio or Tuberculosis  |
| <input type="checkbox"/> Diverticulitis                  | <input type="checkbox"/> Pulmonary Embolism     |
| <input type="checkbox"/> Fibromyalgia                    | <input type="checkbox"/> Reflux or Ulcers       |
| <input type="checkbox"/> Gout                            | <input type="checkbox"/> Stroke or Heart Attack |
| <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Thyroid Disorder       |
| <input type="checkbox"/> Hiatal Hernia or Reflux Disease |   |

## Past Surgical History

Surgery	Reason	Year	Hospitalized Y or N
_____	_____	_____	_____
_____	_____	_____	_____

## Medications

Drug	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Family Health History

	Age	Health Status	If Deceased	Cause of Death
Mother	___	_____	_____	_____
Father	___	_____	_____	_____
Sisters	___	_____	_____	_____
Brother	___	_____	_____	_____

### General

- Recent weight gain
- Recent weight loss
- Fatigue
- Fever
- Bleeding
- None

### Eyes

- Pain
- Loss of Vision
- Double or blurred
- Dryness
- None

### Ears/Nose/Mouth/Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Sinus infection
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness
- Hoarseness
- Difficulty swallowing
- None

### Kidney/Urine/Bladder

- Urgency
- Incontinence
- Retention
- Discharge from penis/vagina
- Prostate trouble
- None

### Lymphatic

- Swollen Glands
- Tender Glands
- None

Endocrine

- Thyroid problems
- Other \_\_\_\_\_
- None

Mood

- Depression
- Anxiety
- None

Heart and Lungs

- Pain in chest
- Irregular heart beat
- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- High blood pressure
- Heart murmur
- Cough
- Coughing blood
- Wheezing
- Night sweats
- None

Stomach and Intestines

- Nausea
- Vomiting
- Stomach pain
- Yellow/Jaundice
- Constipation
- Persistent Diarrhea
- Blood in stools
- Black stools
- Heartburn
- None

Skin

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitivity
- Tightness
- Nodules/bumps
- Hair Loss
- Color changes of hands or feet in the cold
- None

Muscle/Joint/Bones

- Morning stiffness
- Joint pain
- Muscle tenderness
- Other \_\_\_\_\_
- None

Sleep

- Do you sleep well?
- Do you wake feeling rested?
- Do you fall asleep during the day?
- Do you snore loudly?

Exercise

- Occasional
- Moderate
- High level
- None

Caffeine

- Occasional
- Moderate
- Heavy
- None

Cups per day \_\_\_\_\_

Alcohol

- Occasional
- Moderate
- None

How often?

- Less than 3 x week
- More than 3 x week

How many drinks per week ? \_\_\_\_\_

Tobacco

- Currently using tobacco products
- Past use of tobacco products

Cigarettes \_\_\_\_ pks/day

Chew \_\_\_\_\_times/day

Cigars \_\_\_\_\_times/day

#of years \_\_\_\_\_

Year quit \_\_\_\_\_

Drugs

- Currently use recreational/street drugs
- Previously used recreational/street drugs

Please list \_\_\_\_\_

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