IMS
INTEGRATED MEDICAL SERVICES

Personal Information

Patient First Name: _____ Initial: _____ Last Name: _____

DOB: _____ Age: _____ Social Security #: _____ Email: _____

Address: _____
Street Apt # City/State/Zip

Home Phone: _____ Work Phone: _____ Cell phone: _____

Gender : M F Language: ENG SPAN OTHER: _____ Marital Status: S M W D O

Race/Ethnicity: ____ White ____ Black/African American ____ American Indian ____ Alaska Native ____ Asian

____ Native Hawaiian/Pacific Islander ____ Hispanic/Latino ____ Other_____

Occupation: _____ Retired: _____ YES _____ NO From: _____

Employer Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Financial Responsible Party Information

Responsible Party Name: _____ Relationship to patient: _____

DOB: _____ Age: _____ Social Security #: _____

Emergency Contact Information

Name: _____ Phone Number: _____

Relationship to patient: _____ Date of Birth: _____

Insurance Information

***Primary Insurance**: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

***Secondary Insurance**: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Preferred Pharmacy Information

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Address/ Major Cross Streets: _____ City/State/Zip: _____

Mail-order Pharmacy: _____ Phone #:_____ Fax #: _____

Address: _____ City/State/Zip: _____

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Advanced Directives

Do you have a living will? _____ YES _____ NO Current copy provided: _____ YES _____ NO

Do you have a durable power of attorney for healthcare? _____ YES _____ NO Current copy provided: _____YES _____ NO

Are you an organ donor? _____ YES _____ NO Donor card/copy provided: _____ YES _____ NO

Medical History

Current	Past		Current	Past	
		Anemia			Heart Disease
		Arthritis			Hepatitis
		Asthma			Hernia
		Birth Defect			HIV/AIDS
		Bladder/Urinary Problem			Hypertension
		Bleeding Disorder			Irritable Bowel
		Broken Bones			Kidney Disease
		Cancer			Lupus
		Chest Pain			Lyme Disease
		Colitis			Prostate
		COPD			Seizures
		Depression			Skin Disorder
		Diabetes			Sleep Disorder
		Enphysema			Stomach Ulcer
		Epilepsy			Stroke
		Fibromyalgia			TB
		Goiter			Thyroid Disease
		Headaches			Valley Fever
		Hearing Impaired			Vision Impairment
		Heart Attack			Weight Loss/Gain

Immunizations & Screenings

Measles			OPV					
Mumps			DPT					
Rubella			HBV				HIB	
Pneumonia								
Influenza								
Td								
PAP/PSA								
Colon								
Mammo								

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Family Medical History

	Mother	Father	Grandparent Maternal/Paternal		Sibling Brother/Sister		Child
Alzheimer's							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer							
COPD							
Depression							
Diabetes							
Epilepsy							
Genetic/Birth Disorder							
GI Disorder							
Heart Attack							
Hypertension							
Kidney Disease							
Migraine							
Seizure							
Stroke							
Other							

Pregnancy History (Female patients only)

Have you ever been pregnant? _____ YES _____ NO

If yes, complete below:

	Year	Live Birth?		Vaginal	Cesarean	Miscarriage	Abortion	Still Birth
		Yes	No					
#1								
#2								
#3								
#4								
#5								
#6								
#7								
#8								
#9								
#10								

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Surgical History

Appendix Removal _____
Bone Repair _____
Breast Biopsy _____
Cataract Surgery _____
Colon/Partial Colon _____
Removal (Colectomy) _____
Dilation & Curettage _____
Fistula Insertion _____
Foot Surgery (circle) Right Left
Gall Bladder Removal _____
Heart Bypass Graft _____
Heart Valve Replacement

Hernia Repair _____
Hip Surgery (circle) Right Left
Hysterectomy _____
Knee Surgery (circle) Right Left
Mastectomy (circle) Partial Modified
Total Radical
Prostate Removal _____
Skin Graft _____
Spleen Removal _____
Tonsillectomy _____
Wound Debridement _____
Other _____

Social History

Alcohol Use: FREQUENT SOCIAL NEVER Previous History of Alcohol Use: _____

Tobacco Use: SMOKING FORMER SMOKER NEVER SMOKED

Type: Cigarettes Cigars Other: _____ Current Amount: _____

Previous History of Tobacco Use: _____Past Amt: _____

Caffeine Use: FREQUENT SOCIAL NEVER Explain: _____

Allergies

No known food/pet allergy: ☐ No known medication/drug allergy: ☐

Please list any food/pet allergies: _____

Please list any medication/drug allergies: _____

Current Medication

Do you currently have a Medi-port? _____ YES _____ NO

_____ Medication/Dosage	_____ Frequency	_____ Medication/Dosage	_____ Frequency
_____ Medication/Dosage	_____ Frequency	_____ Medication/Dosage	_____ Frequency
_____ Medication/Dosage	_____ Frequency	_____ Medication/Dosage	_____ Frequency