

Roswell Internal Medicine Specialists, P.C.
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PERSONAL INFORMATION

Name: _____ **Date:** _____
Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____
Occupation: _____

MEDICAL HISTORY

Current Medications: _____

Current Health Problems:

Previous Health Problems:

****ALLERGIES****
MEDICATION **OTHER THAN MEDICATION**

HOSPITALIZATIONS

Description

Year

Hospital

Illness: (kind) _____

Surgery: (kind) _____

Other: (reason) _____

FAMILY HISTORY

	Living	Deceased	If deceased, please list cause.
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling's	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is there any family history of:

	Yes	No	Who?		Yes	No	Who?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____				

PERSONAL HABITS

	Yes	No	If yes, how much/how often?
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you chew Tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	_____

FOR WOMEN ONLY

Menstrual Periods? _____	Pregnancies: _____
Age Onset _____	Live Births _____ Caesarian _____
Date of last Period _____	Premature _____ Miscarriages _____
Difficulty with periods _____	Do you use birth control pills _____
Specify _____	Do you practice self breast examinations? _____
Age of menopause _____	Date of last PAP smear: _____
Lumps or discharge from breasts? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last mammogram: _____

PATIENT MEDICAL HISTORY

Please check NO or YES as applicable. If yes, give a brief description of problem.

NO	YES	NO	YES
<input type="checkbox"/> Weight Change	<input type="checkbox"/>	<input type="checkbox"/> Black stool	<input type="checkbox"/>
<input type="checkbox"/> Appetite change	<input type="checkbox"/>	<input type="checkbox"/> Inability to control stool	<input type="checkbox"/>
<input type="checkbox"/> Fever / Chills	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/>
<input type="checkbox"/> Night Sweats	<input type="checkbox"/>	<input type="checkbox"/> Constipation	<input type="checkbox"/>
<input type="checkbox"/> General weakness	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/>
<input type="checkbox"/> Dizziness, whirling or feeling faint	<input type="checkbox"/>	<input type="checkbox"/> Hernia	<input type="checkbox"/>
		<input type="checkbox"/> Ulcer Disease History	<input type="checkbox"/>
		<input type="checkbox"/> Gall Bladder Disease History	<input type="checkbox"/>
ENDOCRINE SYSTEM		<input type="checkbox"/> Pancreatitis history	<input type="checkbox"/>
<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/>		
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/>	LUNG	
<input type="checkbox"/> History of neck surgery or irradiation	<input type="checkbox"/>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>
<input type="checkbox"/> Increase in thirst	<input type="checkbox"/>	<input type="checkbox"/> Shortness of breath on exertion	
<input type="checkbox"/> Increase in urination	<input type="checkbox"/>	<input type="checkbox"/> Sit up to breathe	<input type="checkbox"/>
		<input type="checkbox"/> Get up after going to sleep to get get breath	
EYES		<input type="checkbox"/> Cough now? How long?	<input type="checkbox"/>
<input type="checkbox"/> Failing vision / blind	<input type="checkbox"/>	<input type="checkbox"/> Phlegm: volume, color, odor, viscosity	<input type="checkbox"/>
<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/> Cough blood	<input type="checkbox"/>
<input type="checkbox"/> Double vision	<input type="checkbox"/>	<input type="checkbox"/> Wheezing	<input type="checkbox"/>
<input type="checkbox"/> Pain	<input type="checkbox"/>	<input type="checkbox"/> Blueness in the lip or fingertips	<input type="checkbox"/>
<input type="checkbox"/> Glasses	<input type="checkbox"/>	<input type="checkbox"/> Asthma history	<input type="checkbox"/>
		<input type="checkbox"/> Pneumonia history	<input type="checkbox"/>
EARS, NOSE, THROAT		<input type="checkbox"/> History of tuberculosis or exposure to tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Difficulty hearing / deaf	<input type="checkbox"/>	<input type="checkbox"/> Skin test for tuberculosis Positive or Negative (circle)	<input type="checkbox"/>
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/> Chest x-ray in last year	<input type="checkbox"/>
<input type="checkbox"/> Nose bleed	<input type="checkbox"/>	<input type="checkbox"/> History of Respiratory infections, give frequency	<input type="checkbox"/>
<input type="checkbox"/> Hoarseness	<input type="checkbox"/>		
<input type="checkbox"/> Sinusitis	<input type="checkbox"/>	HEART AND BLOOD VESSELS	
		<input type="checkbox"/> Chest Discomfort	<input type="checkbox"/>
GASTROINTESTINAL SYSTEM		<input type="checkbox"/> Fainting spells	<input type="checkbox"/>
<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/> Palpitations	<input type="checkbox"/>
<input type="checkbox"/> Vomiting	<input type="checkbox"/>	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/>
<input type="checkbox"/> Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/> Pain in legs, calves, or feet while walking	<input type="checkbox"/>
<input type="checkbox"/> Difficulty in swallowing	<input type="checkbox"/>	<input type="checkbox"/> Swelling or pain in calves	<input type="checkbox"/>
<input type="checkbox"/> Indigestion / Heartburn	<input type="checkbox"/>	<input type="checkbox"/> Hypertension history	<input type="checkbox"/>
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/> Heart murmur	<input type="checkbox"/>
<input type="checkbox"/> Abdominal swelling	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>
<input type="checkbox"/> Jaundice	<input type="checkbox"/>		
<input type="checkbox"/> Red blood in stool	<input type="checkbox"/>		

PATIENT MEDICAL HISTORY (Page 2)

GU SYSTEM (GENERAL)		NERVOUS SYSTEM	
NO	YES	NO	YES
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MALE GENITALIA		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEMALE GENITALIA		<input type="checkbox"/>	<input type="checkbox"/>

Last menstrual period: _____

Patient name: _____

Date: _____

Patient Profile

Name: _____

Social Security _____ Sex: _____

Address: _____

Date of Birth: _____

City, State: _____

Marital Status: _____

Phone: _____ () Home () Work () Other

Referring Physician: _____

Phone: _____ () Home () Work () Other

Primary Physician: _____

PATIENT EMPLOYMENT

() Employed () Retired () Other

Phone: _____

Employer: _____

GUARANTOR

() Same as Patient

Name: _____

Address: _____

City, State: _____

CONTACTS

EMPLOYMENT

Employer: _____

Phone: _____

Phone: _____

Social Security: _____

Date of Birth: _____

PRIMARY INSURANCE

() Same as Patient () Same as Guarantor () Other

Insured Party: _____

Social Security #: _____

Relationship to Patient: _____

Insured ID: _____

Insured Phone: _____

Policy Group: _____

Company: _____

Date of Birth: _____

SECONDARY INSURANCE

() Same as Patient () Same as Guarantor () Other

Insured Party: _____

Social Security #: _____

Relationship to Patient: _____

Insured ID: _____

Insured Phone: _____

Policy Group: _____

Company: _____

Date of Birth: _____