BLOOMINGDALE MEDICAL ASSOCIATES
PATIENT INFORMATION

Account #: _____

Date: _____

Patient's Name: _____ SS #: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____ May we use email for medical results? ( ) Yes ( ) No

Northern Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Parent or Guardian (If a minor): _____

Parent's Employer: _____ Work Phone #: _____

Spouse's Name: _____ Employer: _____ Work Phone #: _____

Emergency Contact Name: _____ Daytime Phone #: _____ Cell Phone #: _____

Current Local Pharmacy

Name: _____

Address: _____

Phone #: _____

If you are here today as the result of an accident, please briefly explain the nature of the injury.

_____

_____

Date of Accident: _____ ( ) Auto ( ) Other

How were you referred to our office:
( ) Referring Physician: _____
( ) Friend ( ) Yellow Pages ( ) Other

I understand that I am solely responsible for services rendered at the time of service. In the event that insurance is filed on my behalf for payment of medical and/or surgical services in the office/hospital, I authorize payment on benefits to BLOOMINGDALE MEDICAL ASSOCIATES. I understand that I am responsible for any amount not covered by my insurance company.

I authorize _____ to receive my medical information.
Family Member / Friend Name

I authorize the release of any medical information necessary for payment to be sent to BLOOMINGDALE MEDICAL ASSOCIATES.

Signature: _____ Date: _____

Today's visit will be paid by: ( ) Cash ( ) Check ( ) Visa / Mastercard / Discover / American Express

Bloomingdale Medical Associates

Established Patient History Form

Note: This Is A Confidential Record And Will Be Kept In Your Doctor's Office. Information Contained Here Will Not Be Released To Anyone Without Your Authorization To Do So.

Last Name:_____First Name:_____DOB:_____ Date:_____

Review Of Systems

Do You Now Or Have You Had Any Problems Related To The Following Systems?

Circle Yes Or No

Constitutional Symptoms	Now	Past	(Comments)
Weight Change	Y N	Y N	
Chills	Y N	Y N	
Sleep Disorder	Y N	Y N	
Other			
Eyes			
Double Vision	Y N	Y N	
Glaucoma	Y N	Y N	
Cataracts	Y N	Y N	
Other			
Ear/Nose/Throat/Mouth			
Hearing Changes	Y N	Y N	
Sore Throat	Y N	Y N	
Sinus Problem	Y N	Y N	
Other			
Cardiovascular			
Chest Pain	Y N	Y N	
Irregular Heartbeat	Y N	Y N	
Swelling In Ankles	Y N	Y N	
Other			
Psychologic			
Are You Generally Happy?	Y N	Y N	
Do You Feel Depressed?	Y N	Y N	
Do You Feel Anxious?	Y N	Y N	
Do You Feel Safe In Your Home?	Y N	Y N	
Endocrine			
Excessive Thirst	Y N	Y N	
Too Hot/Cold	Y N	Y N	
Tired/Sluggish	Y N	Y N	
Other			
Hematologic/Lymphatic			
Swollen Glands	Y N	Y N	
Blood Clotting Problem	Y N	Y N	
Bruising	Y N	Y N	
Other			
Allergic/Immunologic			
Hay Fever	Y N	Y N	
Drug Allergies	Y N	Y N	
Food	Y N	Y N	
Other			

Genitourinary	Now	Past	(Comments)
Change In Stream	Y N	Y N	
Nocturia (Getting Up At Night)	Y N	Y N	
Urinary Frequency>8times/Day	Y N	Y N	
Other			
Musculoskeletal			
Bone Pain	Y N	Y N	
Muscle Pain	Y N	Y N	
Joint Pain	Y N	Y N	
Other			
Integumentary (Skin)			
Rash	Y N	Y N	
Lumps Or Bumps	Y N	Y N	
Moles, Skin Tags	Y N	Y N	
Other			
Neurological			
Tremors	Y N	Y N	
Dizzy Spells	Y N	Y N	
Numbness/Tingling	Y N	Y N	
Other			
Respiratory			
Wheezing	Y N	Y N	
Frequent Cough	Y N	Y N	
Shortness Of Breath	Y N	Y N	
Other			
Gastrointestinal			
Abdominal Pain	Y N	Y N	
Nausea/Vomiting	Y N	Y N	
Indigestion/Heartburn	Y N	Y N	
Other			
Sexual History			
Change In Sex Drive?	Y N	Y N	
Sexual Performance Satisfactory?	Y N	Y N	
Other (I.E. Sexual Trauma)			
Last Exams: Please Enter Date (Mo/Yr)			
Dental:_____	Eye:_____		
Prostate:_____	Psa Test:_____		
Mammogram:_____	Bone Density:_____		
Pelvic:_____	Colonoscopy:_____		
Pap Smear:_____			

Living Will? ☐ Yes ☐ No Advanced Directives? ☐Yes ☐No

List Any Changes In Your Social History For The Past 2 Years (Marital Status, Smoking Status, Alcohol, Occupation, Exercising)

_____

_____

List Any Changes In Your Personal Medical History For The Past 2 Years. (New Medical Diagnosis, Allergies, Medication, Surgical)

_____

_____

List Any Changes In Family History (Blood Relatives) For The Past 2 Years.

_____

_____

Dr/PA/NP Signature:_____ Date: _____

Patient Signature: _____ Date: _____