Better Internal Medicine
Dr. Wallace R. Hodges, MD
Cabrini Medical Tower
901 Boren Avenue, Ste 615
Seattle, WA 98104
Phone: (206) 467-1457 Fax: (206) 467-1347
BetterInternalMedicine.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name:_____Date of Birth:_____

Street:_____City/State/Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____

May we leave a medically related message at home?_____ at work?_____ on cell?_____

Referred by:_____

Emergency contact:_____Phone:_____

Pharmacy:_____Phone:_____

Employer: _____Marital status: Single / Married / Civil union / other (pls. describe)

RESPONSIBLE PARTY INFORMATION

Name:_____Street:_____

City/State/Zip:_____Phone:_____

INSURANCE INFORMATION

Insurance Company:_____Subscriber:_____

Address:_____Subscriber DOB:_____

Patient SS#:_____ Subscriber SS#:_____

Group #:_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer/Address/Phone:_____

I authorize the release of any medical or other information necessary to process claims to my insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Mountain View Natural Medicine. I authorize payment of medical benefits to Mountain View Natural Medicine for services rendered at this clinic and submitted to my insurance carrier.

_____

Signature Date

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PATIENT INTAKE FORM

Name:_____ Date of Birth:_____

Would you like us to be your primary care provider? Y/N Name of other PCP if applicable: _____

Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition:
1. _____
2. _____
3. _____
4. _____

What do you believe is causing your most important health concerns?

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Date began:	Dose:

Supplements:	Reason:	Date began:	Dose:

**Please list any drug allergies: _____

PAST MEDICAL HISTORY: PLEASE LIST ANY SURGERIES:

Age or date:	Description:

Patients often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with your other providers regarding your healthcare?

___yes/no___

PAST MEDICAL HISTORY: PLEASE LIST ANY MAJOR ILLNESSES:

Age or date:	Description:

CURRENT HEALTH CONCERNS (Review of Systems): Please check normal or abnormal and briefly explain.

N AbN

__ __ Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____
_____
__ __ Head: headaches, vertigo, injuries etc.)_____
__ __ Vision/eye problems: _____
__ __ Ear/nose/throat/mouth (allergies, infections etc.)_____
__ __ Cardiovascular: (high BP, cholesterol etc.) _____
__ __ Respiratory_____
__ __ Digestive tract issues: (changes in bowel habits, hemorrhoids, bloating, pain, etc.) _____
_____
__ __ Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness):_____
_____
__ __ Skin (eczema, infections, rashes, etc.) _____
__ __ Psychological (mood changes, sadness, irritability, anxiety etc.) _____
_____
__ __ Neurological (numbness, tingling, balance problems, memory etc.) _____
_____
__ __ Hormonal issues (diabetes, thyroid problems, menopausal, adrenal etc.) _____
_____
__ __ Blood or lymph issues (current anemia, swollen glands etc.) _____
__ __ Allergies _____
__ __ Others:_____

WOMEN:

Onset of first menses was age___. Periods generally last ___ days and occur every ___ days.
Date of last period _____ Bleeding is __Heavy __Moderate __Light
Do you experience PMS symptoms?_____ List:_____
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
Type of birth control: _____ Are you happy with this method? _____
Are you currently experiencing any gynecological symptoms or problems?_____
_____
Any problems related to sexual function?_____
Do you have a history of sexually transmitted disease?_____ Genital warts?_____
Number of pregnancies?____ Births?____ Abortions?____ Miscarriages?____

Date of last Pap smear: _____ Abnormal Pap History: _____
Do you perform regular breast self exams?_____ Date of last mammogram, if any: _____
If menopausal or perimenopausal, list symptoms and concerns:_____

MEN:
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
History of sexually transmitted diseases?_____ Genital warts?_____
Date of last prostate exam?_____ PSA test? _____
Trouble with urination? (frequency, hesitancy, pain, dribbling)_____
Trouble with sexual function/libido?_____ If yes, explain:_____

GENERAL

Please fill in what you can:

	Recent	Past year	Past 5 years
Weight			
Height			
Cholesterol w/HDL,LDL			
Blood pressure			

If tested in the past 2 years, please check:
_____Thyroid (normal? y/n) ____ Blood sugar (normal? y/n) ____Anemia (normal? y/n)
Date of last:
Tetanus shot _____ Colonoscopy _____ (normal? y/n)

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

DIET: Please describe a typical day's diet for you, (be honest).

Breakfast	Lunch	Dinner	Snacks (what hour)

SOCIAL HISTORY. Please list sources and amounts of:
Caffeine:_____
Alcohol:_____
Smoking history and amount:_____
Recreational drugs: _____

LIFESTYLE:
What is your vocation? _____
What are your primary sources of stress?_____
_____
How much do you think they impact you life?_____
How many hours do you work per week?_____ Number of play/relaxation hours?_____
What do you do in order to manage stress and take care of yourself?_____
_____
What is your exercise routine?_____
Do you wear seatbelts? Y/N. A bike helmet? Y/N

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?

What specific change(s) are YOU ready to make in order for you vision of health to happen?

What, if any, barriers to this exist? How could you overcome these?

How ready do you feel, on a scale of 1 to 10, to make the changes above?

1 2 3 4 5 6 7 8 9 10

(not sure) (depends how hard it is) (I'll do what it takes!)

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Mountain View Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Office Manager
(206) 467-1457

I also understand that I am entitled to receive updates upon request if Mountain View Natural Medicine amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient.

_____ _____
Date Patient's name if not signed by patient

THIS SECTION IS TO BE COMPLETED BY Mountain View Natural Medicine IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____
Name and title of employee Date