Cherokee Internal Medicine, P.C.

Patient Demographics

First Name: _____ **Last Name:** _____ **M.I.** _____

Preferred Name: _____ **Date of Birth:**_____ **Sex: Male** ⬜ **Female** ⬜ **Other** ⬜

Address: _____ **Apt. #** _____

City: _____ **State:**_____ **Zip:** _____

Home Phone:_____**Cell Phone:**_____**Work Phone:** _____ **Ext.** _____

Email Address: _____

Marital Status: Single⬜ Divorced ⬜ Married ⬜ Widowed ⬜ Seperated ⬜ Domestic Partnership ⬜

Race: American Indian/Alaska Native ⬜ Asian ⬜ Native Hawaiian⬜ White ⬜ Hispanic ⬜
Black or African American ⬜ Pacific Islander ⬜ Other Race⬜ _____ Unreported/Refused to Report ⬜

Employer Information: Employer Name: _____ Occupation: _____

Insurance Information: Insurance Plan Name & Address: _____

Name of Insured: _____ Relation: _____ D.O.B. _____

ID/Contract # _____ Group # _____

Please email the front and back of your insurance card to CIMoffice@cherokeeim.com before your appointment to verify eligibility.

Preferred Pharmacy: Name _____ Location _____

How did you hear about us? _____

Advance Directive:

Do you have an Advance Directive/Living Will? Yes ⬜ No ⬜

Who is your healthcare agent? _____

Please bring a copy of your advance directive documents to your appointment to be scanned into your chart

Emergency Contact Information:

Name: _____ Relation: _____

Cell/Home Phone: _____ Work Phone: _____

Do we have permission to discuss medical information with the person above? YES ⬜ **NO** ⬜

I hereby grant permission to Cherokee Internal Medicine to view my prescription history from external sources.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Cherokee Internal Medicine, P.C.
Medical Intake

Name:_____ DOB:_____

Please answer all questions that apply to you and be specific where applicable. Thank you!

MEDICATIONS

Prescription Medications: List all prescription medications that you take regularly and as needed.
Example: Lisinopril 5mg, 1 tablet once a day

OTC Meds/Supplements: List all non-prescription medication that you take, even as needed.
Example: Vitamin D3 1000units 1 capsule once a day, Claritin 10mg 1 tablet, daily during spring

Allergies: Please list all known allergies (including medications, immunizations, foods, etc.) and describe the reaction(s) you experienced for each.

⬜ I have no known drug allergies.

SOCIAL HISTORY

Do you exercise regularly? **Yes** **No** Times per day/week? _____
Type of exercise:_____

Are you a user of tobacco? **Yes** **No** (If yes, please answer the following)

Current Smoker ⬜ How many packs per day? _____ What year did you start smoking? _____

Former Smoker ⬜ How many packs per day? _____ What year did you start smoking? _____

What year did you quit smoking? _____

Chewing Tobacco ⬜ **Snuff user** ⬜ **Other:**_____ What year did you start? _____

Are you exposed to second-hand smoke? **Yes** **No**

Do you vape or use e-cigarettes? **Yes** **No** What year did you start? _____

Do you drink alcohol? **Yes** **No** (If yes, please answer the following)

How often do you have a drink containing alcohol? (circle your answer)

Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking? _____

How often do you have 6 or more drinks on one occasion? ____

Do you feel you have a dependency on alcohol? **Yes** **No**

Do you use illicit drugs? **Yes** **No** If yes, what type? _____ IV drug use? _____

Have you misused prescription drugs or used illicit drugs other than those for medical reasons in the past 12 months? **Yes** **No**

PAST MEDICAL HISTORY

Hospitalizations: List all hospitalizations with dates *(MM/YYYY)*

Surgeries: List all surgeries with dates (include left or right if applicable)

Indicate any major childhood illnesses/surgeries/hospitalizations:

MEN *(Circle your answer)*

Do you perform self-testicular exams?	**Yes No**	Hypospadias?	**Yes No**
Dribbling with urination?	**Yes No**	Rash or blisters on penis?	**Yes No**
Difficulty initiating a stream?	**Yes No**	Undescended testicle?	**Yes No**
Hernia?	**Yes No**	Hard testicles?	**Yes No**
Penile Discharge?	**Yes No**	Lump in groin?	**Yes No**
Scrotal Swelling?	**Yes No**	Scrotal Pain?	**Yes No**

WOMEN *(Circle your answer)*

Age at first period: _____ Number of pregnancies: _____ Number of living children: ____ Birth control method: _____ Do you currently see a gynecologist? **Yes No** Are you currently pregnant ? **Yes No Unsure**	Breast Lumps? **Yes No** Breast Pain? **Yes No** Nipple Discharge? **Yes No** Painful Menses? **Yes No** Hot Flashes? **Yes No** Painful intercourse? **Yes No** Missed Menses? **Yes No** Irregular Menses? **Yes No** Vaginal Discharge? **Yes No** Vaginal Itching? **Yes No** Heavy bleeding during menses? **Yes No** Are you currently breastfeeding? **Yes No**

DATES OF PREVENATIVE SCREENINGS

Last Wellness Exam/Physical (mm/dd/yyyy): _____ Last Lab Work: _____
Previous Primary Care Doctor: _____ Where:_____ Last seen: _____

Colorectal Cancer Screening: (circle answer)

Colonoscopy FIT/FOBT Cologuard Shield Other:_____

When:_____ Who/Where:_____ Result:_____

⬜ I have not completed this screening before ⬜ I decline further colorectal cancer screenings

Breast Cancer Screening:

Mammogram: _____ Where? _____ Result:_____

⬜ I have not completed this screening before ⬜ I decline further breast cancer screenings

Cervical Cancer Screening:

Last Pap Smear: _____ Where? _____ Result: _____

⬜ I have not completed this screening before ⬜ I decline further cervical cancer screenings

Bone Density Test:

When: _____ Where? _____ Result: _____

Cardiac Testing:

EKG:_____ Echocardiogram (ECHO): _____ Cardiac Stress Test: _____

Vision Screening:

Eye Exam:_____ Who/Where? _____ ⬜This was a diabetic eye exam

Hearing Screening: _____ Who/Where? _____

Hepatitis C Screening: _____ Where? _____ Result: _____

STI Screening: _____ **HIV Testing**: _____

Tuberculosis testing (TB):

TB Skin/ TB Blood: _____ Result: _____ If positive, date of last chest x-ray? _____

PAST MEDICAL HISTORY: (Please check all that apply)

☐	Alcohol Dependency	☐	Epilepsy	☐	Mononucleosis
☐	Alzheimer's/Dementia	☐	Seizures	☐	Multiple Sclerosis
☐	Anemia	☐	Glaucoma	☐	Osteoporosis
☐	Anxiety	☐	Gout	☐	Pacemaker
☐	Arthritis	☐	Hay Fever/Sinus Disease	☐	Parkinson’s
☐	Asthma	☐	Heart Attack	☐	Prostate Problems
☐	Bipolar Disorder	☐	Heart Failure	☐	Rheumatic Fever
☐	Blood Clots/Phlebitis	☐	Heart Murmur	☐	Sexually Transmitted Disease
☐	Bleeding Disorder	☐	Hemorrhoid	☐	Skin Disorder
☐	Breast Lump	☐	Hepatitis/Liver Disease	☐	Sleep Disorder
☐	Cancer	☐	Epilepsy	☐	Thyroid Problems
☐	Cardiac Arrhythmia/A-Fib	☐	Seizures	☐	Tremors
☐	Cataracts	☐	High Blood Pressure	☐	Tuberculosis
☐	Chronic Kidney Disease	☐	High Cholesterol	☐	Ulcers
☐	Colitis	☐	HIV Positive	☐	Recurrent UTI (bladder/kidney infection)
☐	Colon Polyp	☐	High Blood Pressure	☐	Other:
☐	COPD	☐	Irritable Bowel Syndrome (IBS)		
☐	Depression	☐	Kidney Stone		
☐	Diabetes Type 2	☐	Macular Degeneration		
☐	Diverticulitis	☐	Migraine		
☐	Eating Disorder	☐	Headaches		

Relation	Year of Birth	Age at Death	Cause of Death	Medical History
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Brother #1				
Brother #2				
Brother #3				
Sister #1				
Sister #2				
Sister #3				

FAMILY HISTORY

Has your blood relative ever had any of the following? Please include paternal/maternal to with Aunts, Uncles, Grandparents and numbers with siblings (example: sister #1, brother #2)

Arthritis	
Anemia	
Cancer (Type/Location)	
Diabetes (Type 1 or Type 2)	
Heart Disease/Stroke	
High Blood Pressure	
Mental Illness/Chemical Dependency	
Osteoporosis	
Tuberculosis	
Thyroid	
Seizures/Mirgraines	

Do you see any specialists? If yes, please provide facility name and doctor name.

Speciality	Provider Name	Office/Location
Cardiologist/Heart		
Dermatologist/Skin		
Endocrinologist		
Gastroenterologist/Stomach		
Gynecologist/Woman		
Hematologist/Oncologist		
Nephrologist/Kidney		
Neurologist		
Ophthalmologist/Eye		
Optometrist/Eye		
Orthopedist/Bone		
ENT		
Pulmonologist/Lung		
Psychiatrist		
Psychologist/Therapist		
Rheumatologist		
Urologist		
UroGynecologist		
Other:		

I certify that the above information is accurate and complete to the best of my knowledge.

Signature:_____ **Date:**_____