KARU
Medical Associates

A Patient Centered Medical Home

Instructions: Please fill out as completely as possible. All information will be kept confidential.

PATIENT ID

Name – Last	First	Middle	Date of Birth	Sex
				☐ M ☐ F

Address – Number & Street	City	State	Zip

Home Phone	Cell Phone	Work Phone

Occupation	Employer Name

Emergency Contact:	Name	Relationship	Phone

CURRENT MEDICAL PROBLEMS

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you

ILLNESS OR MEDICAL PROBLEM	PHYSICIAN TREATING YOU

OTHER MEDICAL INFORMATION

Do you have a pacemaker? YES ☐ NO ☐	Last visit with primary care doctor: Date:_____
Do you have an implanted defibrillator? YES ☐ NO ☐	Name of Doctor:
Do you have breast implants? YES ☐ NO ☐	Last colonoscopy: Date:_____
	Where was it done?

ILLNESSES AND MEDICAL PROBLEMS

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down on approximate year

ILLNESS	X	YEAR	ILLNESS	X	YEAR
Allergies (seasonal, hay fever)	☐	_____	Kidney Stone	☐	_____
Arteriosclerosis	☐	_____	Arthritis (Rheumatoid)	☐	_____
Asthma	☐	_____	Prostate problem	☐	_____
Colitis	☐	_____	Hemorrhoids	☐	_____
Deafness/Hard of Hearing	☐	_____	Mental illness	☐	_____
Diverticulitis	☐	_____	Hernia	☐	_____
Emphysema	☐	_____	Psoriasis	☐	_____
Glaucoma	☐	_____	Kidney or bladder disease	☐	_____
Heart attack	☐	_____	Liver Disease	☐	_____
Heart Disease	☐	_____	Stroke	☐	_____
Heart murmur	☐	_____	Cancer or tumor	☐	_____
High Blood Pressure	☐	_____	Head injury	☐	_____
High Cholesterol	☐	_____	Convulsions, seizures	☐	_____
Other lung problems	☐	_____	Bleeding tendency	☐	_____
Stomach/duodenal ulcer	☐	_____	Epilepsy	☐	_____
Tuberculosis	☐	_____	Diabetes	☐	_____
Other	☐	_____	Migraine headaches	☐	_____

Please list if any, that you have been hospitalized. Don't include normal pregnancies.

YEAR	OPERATION OR ILLNESS	HOSPITAL AND CITY	

MEDICATIONS

Please list all medications you are now taking, including, over the counter medications and supplements. Include the strength and dosage of each medication below.

MEDICATION NAME (IF NO MEDICATIONS, ENTER NONE:	STRENGTH	FREQUENCY

ALLERGIES

List anything that you are allergic to, such as certain foods or medications and indicate how each affects you.

ALLERGIC TO: IF NO ALLERGIES, ENTER NONE	REACTION:
Are you allergic to Latex? ☐ YES ☐ NO	Are you allergic to Bee Stings? ☐ YES ☐ NO

SOCIAL/PERSONAL HISTORY

Currently live:

☐ ALONE ☐ WITH FRIENDS ☐ WITH FAMILY ☐ WITH SIGNIFICANT OTHER

Marital Status:

☐ MARRIED ☐ SPEARATED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

Last grade completed in school:

Smoking history: Do you currently smoke? ☐ YES ☐ NO	How much per day?	How many years?
Are you a former smoker? ☐ YES ☐ NO If yes, how many years? ____ # of packs per day ____ Quit date: _____	Do you chew tobacco? ☐ YES ☐ NO	Are you exposed to second-hand smoke? ☐ YES ☐ NO

Consumption of alcoholic beverages?

☐ YES ☐ NO AMOUNT_____

Do you use drugs? (including marijuana)

☐ YES ☐ NO TYPE:_____ FREQUENCY:_____

Do you exercise regularly?	Do you wear seat belts?
☐ YES ☐ NO HOW OFTEN_____	☐ YES ☐ NO

SOCIAL/PERSONAL NEEDS

Have you been sick and did not get care because you did not have transportation to and from the doctor?

☐ YES ☐ NO

Have you felt that you did not have enough money to pay for your medications or your insurance deductibles/copays?

☐ YES ☐ NO

Have you felt that you ate less because there wasn't enough money for food?

☐ YES ☐ NO

If yes, are you interested in obtaining information on agencies that can help you with this?

☐ YES ☐ NO

FAMILY HEALTH

Please give the following information about your immediate family

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
FATHER			

MOTHER			
BROTHER(S)			
SISTERS(S)			
SPOUSE			
CHILDREN			

Have any blood relatives had any of the following illnesses? If so, indicate relationship by placing an X in the appropriate box.

ILLNESS	FATHER	MOTHER	BROTHER	SISTER
HEART DISEASE				
HIGH BLOOD PRESSURE				
CANCER				
DIABETES				
HYPERCHOLESTEROLEMIA				
RHEUMATOID ARTHRITIS				

REVIEW OF SYSTEMS

Place an X in front of each item that you have now or have had in the past and where applicable, please fill in additional information.

GENERAL ►	weakness fatigue	chills night sweats	change in weight, appetite or sleeping habits	
SKIN ►	itching	rash	change in color	easy bruising
NERVOUS SYTEM ►	headache dizziness	double vision muscle weakness	numbness loss of coordination	
LUNGS ►	cough wheezing	shortness of breath spitting up blood	positive TB test last chest X-ray date:_____	
HEART ►	chest pain palpitations (heart pounding)	trouble breathing at night trouble climbing stairs	easy fatigue ankle swelling	
GASTROINTESTINAL ►	stomach pain/abdominal pain indigestion/heart burn	difficulty swallowing vomiting	changes in bowel habits blood in stools	
URINARY ►	pain on urination blood in urine	frequent urination previous infections	difficulty starting to urinate	
EYES ►	glasses/contacts eye pain	excessive tearing blurring or spots	last eye exam date: _____	
EARS ►	loss of decreased hearing	ringing	drainage	
NOSE/THROAT/SINUSES ►	nosebleed sore throat	hoarseness postnasal drip	swelling	
MOUTH ►	dentures	bleeding gums	toothache	last dental exam:_____
JOINTS & BACK ►	pain	swelling	stiffness	deformity
MUSCLES ►	pain	weakness	twitching	
ENDOCRINE ►	excessively hot excessively cold	always thirsty always hungry		
PSYCHOLOGICAL ►	nervousness depression	unable to sleep nightmares	memory loss	

IMMUNIZATIONS ►

Tetanus/TDap: date: _____ influenza date: _____

Pneumovax date: _____ Shingles Vaccine: date: Zostavax? Shinrgrix?

Prevnar: date: _____

MALE ►

hernia
pain in testicles
sexual difficulties
discharge from penis
sexually transmitted disease

FEMALE ►

vaginal itching or burning
vaginal discharge
problem with menstrual periods
last menstrual period date:_____
last Pap smear date:_____
methods of contraception_____
sexually trans mitted disease
sexual difficulties
pregnancy, number:_____
miscarriages or abortions, number:_____
live births, number:_____
problems during pregnancy
lumps in breast
discharge from nipple
last mammography date: _____

SIGNS & SYMPTOMS & OTHER INFORMATION NOT COVERED ABOVE