Olathe HEALTH
Internal Medicine

20805 W 151st Street
Doctor's Building II, Suite 224
Olathe, KS 66061
913-782-8300
Fax: 913-782-1574

Office Hours:
Monday – Friday: 8 am – 5 pm

Welcome to our practice. We are pleased that you have chosen Internal Medicine Associates of Olathe to provide care for you and your family. Your visit to our office is meant to be a pleasant experience and we ask for your assistance in establishing a good medical relationship. Proper patient registration is important. If this is your first visit, please arrive 20 minutes early. At each visit, please have your current insurance card and photo ID available at check-in. Any applicable co-pay is also required at the time of check-in (as in accordance with insurance guidelines).

For ease of registration, please return the completed forms to Internal Medicine Associates of Olathe three (3) business days prior to your appointment. For your convenience, you may also fax all forms to the following secure fax number – 913-782-1574.

Patient Name: _____Today's Date: _____

Home address: Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Physician: _____ Primary care physician: _____

Birth Date: _____ Sex: M F

Marital Status: Single Married Divorced Widowed

Social Sec #: _____

Emergency Contact: _____Relationship_____

Home Phone: _____ Work Phone: _____

Patient name:_____ Date:_____

Patient Medical History – Please check all that apply to your medical history

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Back/Joint Problems
- ☐ Breast Cancer
- ☐ Chronic Renal Failure
- ☐ Cirrhosis
- ☐ Colon/Bowel Problems
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's/Ulcerative Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallstones
- ☐ GERD
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pancreatitis
- ☐ Peptic Ulcer
- ☐ Prostate Enlargement/Cancer
- ☐ Seizures
- ☐ Strokes/TIA
- ☐ Thyroid Disease

Surgical History – Please check all that apply to your surgical past

- ☐ Appendectomy
- ☐ Breast Lump/Mastectomy
- ☐ Gallbladder Removal
- ☐ Hernia
- ☐ Heart Bypass
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Orthopedic (knee/hip)
- ☐ Pacemaker
- ☐ Prostate
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Other _____

Family History – Please check all that apply to your family medical history

☐ Breast Cancer	Mother	Sister		
☐ Colon Polyps/Colon Cancer	Mother	Father	Brother	Sister
☐ Coronary Artery Disease	Mother	Father	Brother	Sister
☐ Diabetes	Mother	Father	Brother	Sister
☐ Gastric Cancer	Mother	Father	Brother	Sister
☐ Liver Disease	Mother	Father	Brother	Sister
☐ Pancreatic Cancer	Mother	Father	Brother	Sister
☐ Ulceratrive Colitis/Crohns	Mother	Father	Brother	Sister

Social History – Please circle

Marital status: Single Married Divorced Widowed

Smoking/Tobacco Use: Quit No Yes Packs per day_____ Number of years_____

Alcohol Use : Quit No Yes

If yes what type: beer liquor wine how many drinks per day?_____

Caffeine Use Number of cups/drinks a day? _____

Exercise: No Yes How frequently: _____

Preventative Screenings – Please check all that apply

- ☐ Colonoscopy (>age 50) Date: _____
- ☐ Mammography (women age 40-74) Date: _____
- ☐ Any Other Tests _____

Physician/Provider Signature: _____ Date: _____
Patient name:_____ Date:_____

Please indicate if you are *CURRENTLY* having any of the symptoms listed below. By not selecting a symptom you are denying having this problem at this time.

Constitutional ☐ Decrease in appetite ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight loss ☐ Weight gain

Eyes/ENT ☐ Blurred or double vision ☐ Diminished Vision ☐ Drainage ☐ Hoarseness ☐ Hearing loss or ringing ☐ Chronic sinus problems ☐ Nose bleeds

Respiratory ☐ Chronic Cough ☐ Wheezing ☐ Shortness of breath

Endocrine ☐ Increased thirst ☐ Cold/Heat intolerance ☐ Breast Discharge ☐ Change in menstrual cycle

Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ Pacemaker

Hematology ☐ Coumadin treatment ☐ Nose Bleeds ☐ Easy bruising ☐ Swollen glands ☐ Anemia

Genitourinary ☐ Frequent urination ☐ Burning/painful urination ☐ Blood in urine ☐ Decreased flow

Musculoskeletal ☐ Painful joints ☐ Joint swelling ☐ Muscle cramps ☐ Back pain

Skin ☐ Itching ☐ Rash ☐ Hives ☐ Skin Cancer ☐ Dry Skin

Neurological ☐ Dizzy or light headed ☐ Epilepsy ☐ Numbness or tingling ☐ Memory loss ☐ Difficulty speaking

Psychiatric ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Stress ☐ Mood changes

Medications: List all medications you presently take. (include dosage and how often)

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Mail Order: _____

Non-Traditional Medications Please list herbs and/or dietary supplements

Allergies: Drug/Agent Reaction

Physician/Provider Signature: _____ Date: _____