DIAMOND ODELL JUDE, MD.
Internal Medicine

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# New Patient Forms

-Please fill out all the information as best as you can. The nurse will go over the information in the room with you and help answer any questions you have.

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Alt Number: _____

Email: _____

SSN: _____ Occupation: _____

Emergency Contact: _____ Phone number: _____

Pharmacy: _____ Phone number: _____

Medication/Food Allergies: _____

## Medications: currently taking. Please include over the counter and prescribed.

| **Medication Name** | **Dosage(s) /Strength** | **How often do you take it?** (Ex. 1 in the AM, every day) |
|---|---|---|
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## Medical History

Please fill in the circle for all **previous** illnesses or conditions below:

- ◯ Anxiety/Depression
- ◯ Asthma
- ◯ Cancer
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ History of Blood Clots
- ◯ HIV/AIDS
- ◯ Kidney Problems
- ◯ Liver Disease
- ◯ Lung Problems
- ◯ Arthritis
- ◯ Bleeding Disorder
- ◯ Bowel/Intestinal Problems
- ◯ Diabetes (high blood sugar)
- ◯ Hearing Problems
- ◯ Glaucoma/Eye Problems
- ◯ Mental Health Problems
- ◯ Seizures
- ◯ Skin Problems
- ◯ Stomach Problems
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ High Cholesterol
- ◯ Anemia
- ◯ Seasonal Allergies
- ◯ Acid Reflux/GERD

**Comments/Additional information:**_____

_____

_____

_____

_____

**Other Doctors you see: Name and Specialty**

| | |
|---|---|
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| | |
| | |
| | |
| | |

**Concerns you would like to address today and reason for visit:** _____

_____

_____

_____

_____

_____

_____

**Past Surgeries/Hospital stays**

| Date | Surgery type and/or hospital stays |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Family History

Please provide siblings/children history in additional boxes.

| Relation | Mother | Father | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Living or deceased | | | | | | | | | |
| Current age or age of death | | | | | | | | | |
| Diabetes | | | | | | | | | |
| High/Low Blood pressure | | | | | | | | | |
| Heart disease/Heart attack | | | | | | | | | |
| Stroke | | | | | | | | | |
| Mental Illness | | | | | | | | | |
| Cancer | | | | | | | | | |
| Unknown | | | | | | | | | |

**Comments/Additional information:**

_____

_____

_____

_____

_____

## Social History

**Do you smoke? Yes / No / Former Smoker**

If Yes, How often _____ What do you smoke? _____

How long have you smoked? _____ Do you plan on quitting? _____

**Do you drink Alcohol? Yes / No / Former Drinker**

If Yes, How often _____ What do you drink? _____

How much do you normally drink? _____

**Any current or history of illegal drug use? Yes / No**

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## Acknowledgement of receipt of notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by our staff in providing and arranging your medical care.

Permissions regarding the consent to disclose your protected health information for informative purposes and/or treatment provided by Diamond Odell Jude, M.D. are granted on this form.

**HIPAA Information Release**
**Release my information to:**

| | Name | Relationship |
|---|---|---|
| Myself | | |
| Spouse | | |
| Individual | | |
| Individual | | |
| Individual | | |

1.) May our office leave detailed information on your answering machine?
Yes___ No___

2.) May we send appointment reminders and messages via email/text?
Yes ___ No ___

By signing this form, you acknowledge that you have provided Diamond Odell Jude, M.D. LLC with permission/instructions regarding the release of your healthcare information.

_____ _____
**Signature of Patient, Parent or Legal Guardian Date**