FCIM
FREEDMAN
CLINIC
INTERNAL
MEDICINE

OFFICE 176 VERSAILLES BOULEVARD
ALEXANDRIA, LA 71303
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MAILING PO BOX 13030
ALEXANDRIA, LA 71315-3030

PLEASE FILL OUT ALL FORMS AND FAX OR MAIL TO:

FREEDMAN CLINIC OF INTERNAL MEDICINE
P.O. BOX 13030
ALEXANDRIA, LA 71315
FAX: (318) 619-6899

FORMS MUST BE RECEIVED BEFORE YOUR APPOINTMENT OR YOU WILL HAVE TO RESCHEDULE

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____☒/DD_____☒/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:___-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Agnes A. Solon, M.D., F.A.C.R.
Patient History Form

Date of first appointment ___/___/___ Time of appointment: _____ Birthplace _____

Name: _____ Birthdate: ___/___/___
Last First Middle Initial (Maiden)

Address: _____ Age: _____ Sex: ❑ Female ❑ Male
Street Apt.#

_____ Telephone: Home (___) _____
Work (___) _____

Marital Status: ❑ Never Married ❑ Married ❑ Divorce ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ ❑ Major Illness _____

Ethnic Group: ❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other

Please check if this questionnaire is completed entirely by patient ❑ or with help from (home) _____

Please indicate the name, address and phone number of someone who lives at a different address from you, and who will be likely to know your where abouts if we are unable to reach you. Relationship: _____

Name: _____ Address: _____

City, State, Zip: _____ Telephone Number: _____

What is your current occupation? (If you are not working now, what was your past occupation?)

_____

At this time, are you? (*Please check (✓) all that apply*)

_____ Working full time _____ Retired
_____ Working part time _____ Student
_____ Homemaker, full time _____ Disabled
_____ Other _____

How many other people live at home with you? (*Please check (✓) who lives with you.*)

_____ Spouse/partner _____ Parents _____ Sons or daughters _____ I live alone
_____ Other (describe) _____

How many years of school have you completed? (*Please circle the number of years of school.*)

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 11 ❑ 12 ❑ 13 ❑ 14 ❑ 15 ❑ 16

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Address: _____ Phone: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, please name: _____

Describe, briefly, your present symptoms: _____

_____

Date symptoms began (approximate): _____ Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery, and injections; **medications will be listed later**.)

_____

Please list the names of other practitioners you have seen for this problem: _____

_____

Reviewed by: _____ Date: _____

Patient Name: _____

Over the last 6 months, have you had:

____ No	____ Yes	An operation	____ No	____ Yes	Change of address
____ No	____ Yes	Inpatient Hospitalization	____ No	____ Yes	Change of marital status
____ No	____ Yes	A new illness	____ No	____ Yes	Quit work, retired, change job or duties
____ No	____ Yes	An important new symptom	____ No	____ Yes	Change of primary care or other doctor

(Please explain any "Yes" answers below, or write anything else you may think the doctor should know.)

_____

_____

_____

Please list below any medications which you cannot take because you are allergic to them:

_____ _____ _____

Please list below anything else (grass, molds, pollens, etc.) you might be allergic to:

_____ _____ _____

Please write below all the drugs or medicines you have taken over the last two weeks for any condition.
(include aspirin, birth control pills, and any drug or medicine with or without prescription. If additional space is needed list on separate page.

	NAME OF DRUG OR MEDICINE	DOSE (IF KNOWN)	How many per day or week?		NAME OF DRUG OR MEDICINE	DOSE (IF KNOWN)	How many per day or week?
1.				8.			
2.				9.			
3.				10.			
4.				11.			
5.				12.			
6.				13.			
7.				14.			

Do any of the above drugs cause you side effects? ❑ Yes ❑ No (If "Yes", please write the drug(s) and the side effects below)

_____ _____ _____

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) ❑ ❑ ❑					
Circle any you have taken in the past.					
Ansold ☐ (flurbiprofin)	Arthrotec ☐ (diciofenac+misoprostill)	Aspirin (including coated aspirin) ☐	Celebrex ☐ (celecoxib)	Clinorill ☐ (sullindac)	Daypro ☐ (oxoprozin)
Disalcid ☐ (salsalate)	Dolobid ☐ (difiunisal)	Feidene ☐ (piroxicom)	Indocin ☐ (indomethacin)	Lodine ☐ (atodolac)	Meciomen ☐ (meciofenamate)
Motrin/Rufen ☐ (ibuprofen)	Naifan ☐ (fenoprofen)	Noprosyn ☐ (noproxen)	Oruvail ☐ (ketoprofen)	Tolectin ☐ (tolmettin)	Trillsate ☐ (choline magnesium trisolicytc)
Vioxx ☐ (rofecoxib)	Voltaren ☐ (cliciofenac)				

Please list below all operations you have ever had: *Please check (✓) here, if none* _____.

	Operation	Year	Surgeon	Hospital, City, State
1.				
2.				
3.				
4.				

(You may continue on a separate page)

Reviewed by: _____ Date: _____

Patient Name: _____

Please list below all major illnesses or admissions to a hospital (other than for operations):
Please check (✓) here, if none _____.

	illness or reason for hospitalization	**Year**	**Hospital, City, State**
1.			
2.			
3.			
4.			

Please check (✓) either "NO" or "YES" to indicate whether or not you have any of the conditions below:
(*If you answer "YES", please write AGE or YEAR when it began*)

Have you had:			**Age**		**Year**	**Have you had:**			**Age**		**Year**
Hypertension/high blood pressure	❑ No	❑ Yes	_____	or	_____	Gynecological (Female)	❑ No	❑ Yes	_____	or	_____
Heart Attack	❑ No	❑ Yes	_____	or	_____	Prostate (Male)	❑ No	❑ Yes	_____	or	_____
Other Heart Disease	❑ No	❑ Yes	_____	or	_____	Rheumatoid arthritis	❑ No	❑ Yes	_____	or	_____
Cancer	❑ No	❑ Yes	_____	or	_____	Osteoarthritis	❑ No	❑ Yes	_____	or	_____
Stroke	❑ No	❑ Yes	_____	or	_____	Lupus	❑ No	❑ Yes	_____	or	_____
Bronchitis or Emphysema	❑ No	❑ Yes	_____	or	_____	Back or spine problems	❑ No	❑ Yes	_____	or	_____
Asthma	❑ No	❑ Yes	_____	or	_____	Fibromyalgia (Fibrosis)	❑ No	❑ Yes	_____	or	_____
Other Lung problem	❑ No	❑ Yes	_____	or	_____	Osteoporosis	❑ No	❑ Yes	_____	or	_____
Anemia (Low Blood)	❑ No	❑ Yes	_____	or	_____	Dry mouth	❑ No	❑ Yes	_____	or	_____
Other hematologic problem	❑ No	❑ Yes	_____	or	_____	Dry eyes	❑ No	❑ Yes	_____	or	_____
Stomach Ulcer	❑ No	❑ Yes	_____	or	_____	Cataracts	❑ No	❑ Yes	_____	or	_____
Other gastrointestinal (GI) problem	❑ No	❑ Yes	_____	or	_____	Parkinson's disease	❑ No	❑ Yes	_____	or	_____
Diabetes	❑ No	❑ Yes	_____	or	_____	Depression	❑ No	❑ Yes	_____	or	_____
Kidney problem	❑ No	❑ Yes	_____	or	_____	Mental illness	❑ No	❑ Yes	_____	or	_____
Other _____ (Please Name)			_____	or	_____	Severe Allergies	❑ No	❑ Yes	_____	or	_____
						Other _____ (Please Name)			_____	or	_____

The questions below concern your family medical history:

	If Living		**If Deceased**	
	Age(s)	**Any Major Medical Condition**	**Age(s) At Death**	**Cause(s) of Death**
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Son(s)	_____	_____	_____	_____
Daughter(s)	_____	_____	_____	_____

Any blood relative (parent, child, brother, sister, aunt uncle) with: (If "Yes" give relationship)

	No	Yes	Relation(s)		No	Yes	Relation(s)
Rheumatoid Arthritis	____	____	_____	Lupus or SLE	____	____	_____

Any illness which run in the family? _____

Social History

Do you drink caffeinated beverages? ❑ No ❑ Yes
Cups/Glasses per day? _____

Do you smoke? ❑ No ❑ Yes ❑ Past
(If yes, how many per week?) _____

Do you drink alcohol? ❑ No ❑ Yes
(If yes, how many per week?) _____

Has anyone ever told you to cut down on your drinking? ❑ No ❑ Yes

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes
(If yes, please list) _____

Do you exercise regularly? ❑ No ❑ Yes

Type: _____

Amount per week: _____

How many hours of sleep do you get at night? _____

Reviewed by: _____ Date: _____

As you review the following list, please check any of those problems which have significantly affected you.

Please check (✓) if you have experienced any of the following over the last month:

_____ Fever
_____ Weight gain (>10lbs)
_____ Weight loss (<10lbs)
_____ Feeling sickly
_____ Headaches
_____ Unusual fatigue
_____ Swollen glands
_____ Loss of appetite
_____ Skin rash or hives
_____ Unusual bruising or bleeding
_____ Other skin problems
_____ Loss of hair
_____ Dry eyes
_____ Other eye problems
_____ Problems with hearing
_____ Ringing in the ears
_____ Stuffy nose
_____ Sores in the mouth
_____ Dry mouth
_____ Problems with smell or taste

_____ Lump in your throat
_____ Cough
_____ Shortness of breath
_____ Wheezing
_____ Pain in the chest
_____ Heart pounding (palpitations)
_____ Trouble swallowing
_____ Heartburn or stomach gas
_____ Stomach pain or cramps
_____ Nausea
_____ Vomiting
_____ Constipation
_____ Diarrhea
_____ Dark or bloody stools
_____ Problems with urination
_____ Gynecological (female) problems
_____ Dizziness
_____ Losing your balance
_____ Muscle pain, aches, or cramps
_____ Muscle weakness

_____ Paralysis of arms or legs
_____ Numbness or tingling of arms or legs
_____ Fainting of hands
_____ Swelling of hands
_____ Swelling of ankles
_____ Swelling in other joints
_____ Joint pain
_____ Back pain
_____ Neck pain
_____ Use of drugs not sold in stores
_____ Smoking cigarettes
_____ More than 2 alcoholic drinks per day
_____ Depression - feeling blue
_____ Anxiety - feeling nervous
_____ Problems with thinking
_____ Problems with memory
_____ Problems with sleeping
_____ Sexual problems
_____ Burning in sex organs
_____ Problems with social activities

Date of last Mammogram ___/___/___

Date of last Chest X-ray ___/___/___

Date of last Bone Densitometry ___/___/___

Date of last Colonoscopy ___/___/___

Date of last Cholesterol Check ___/___/___

Date of last Eye Exam ___/___/___

Date of last Tuberculosis Test ___/___/___

Date of last Pap Smear ___/___/___

Date of last PSA ___/___/___

Reviewed by: _____ Date: _____