C O - E D
CENTRAL OKLAHOMA EARLY DETECTION
CENTER
ADVANCED LIPIDOLOGY
CARDIOMETABOLIC RISK
OBESITY
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Welcome to Dr. Dimick's Office. We appreciate the opportunity to provide your health care needs. We ask that you carefully read and fill out the following forms and bring them with you to your initial appointment.

The **New Patient Information Form** will provide Dr. Dimick with some background information she will need to treat you. Please fill it out as completely as possible. It is important that you provide a list of medications you currently take with the exact name, dosage (strength) and how often you take them. We also ask that you bring that list (updating as needed) with you to all future appointments.

The **Acknowledgements and Authorizations Forms** explain our billing policy and give us permission to release any information to your insurance company for payment decision; and obtain copies of all pertinent medical records. Dr. Dimick uses such records to have a complete medical history as part of your evaluation process. If you do not have copies of your records, please contact the offices of the physicians you have seen in the past and request copies. It is helpful to bring these records to our office on the day of your appointment if possible.

Please remember to bring your health insurance identification card and an I.D. with you to each appointment. This may be needed to send to labs or testing facilities.

We look forward to seeing you. Please feel free to call us with any questions.

New Patient Information Form

Please assist us by completing the following

Today's Date: Date of Birth:

Name: Age:
LAST FIRST

Address: City:
STREET APT

ST: Zip: E-mail Address:

Home Ph: Cell Ph: Work Ph:

Occupation: Employer:

Who do we contact in case of an emergency?

Name: Relationship: Ph:

MEDICAL HISTORY

Reason for your visit:

Please list your medical history (cancers, infectious diseases, heart, lung, gland, non-surgical, kidney, or gastrointestinal illnesses or disorders). Be sure to list disorders/illnesses for which you take medication:

1. 5.
2. 6.
3. 7.
4. 8.

(If you should need more space, please use a blank sheet of paper and attach it to this form.)

Have you ever had rheumatic fever? If so, when?

Have you ever had a blood transfusion? If so, when?

Please list previous surgeries and approximate date.

1. When:
2. When:
3. When:
4. When:

(If you should need more space, please use a blank sheet of paper and attach it to this form.)

For Women

Number of: pregnancies delivered vaginal births miscarriages

Are you still having menstrual periods? Is your cycle: Regular ☐ Irregular ☐

If yes, when was your last menstrual period?

Form of birth control: Date of last Pap smear?

Have you ever had a mammogram? If so, when?

Have you had an osteoporosis scan (Bone Density)? _____ If so, when? _____ Normal ____ Abnormal ____

Please List Those Illnesses Which Tend To Run In Your Family

Do your grandparents, parents, or siblings have any illnesses? If so, please list them. Do you have a Family History of Diabetes? List any cancers that run in your family. What diseases have family members died from? List ages that your relatives developed Heart Disease or Stroke.

Your Personal History and Medications:

When was your last meal taken? / /

Are you married? Do you smoke? What is your weekly alcohol intake?

What regular exercise are you involved in?

Spouse's occupation

Please List Your Prescription Medication

Medication:	Dosage:	How often you take it:

(If you should need more space, please use a blank sheet of paper and attach it to this form.)

Are you allergic to any medications? If so, please list them and type of reaction:

Have you had any changes in your health that you would like to discuss? If so, please list them. Also, list any longstanding or previous health problems not listed above:

What over-the-counter pills, potions, vitamins, herbs, supplements, lotions, inhalers, creams or ointments are you using? (This includes aspirin and ibuprofen in any form.)

What doctors have you seen in the last 10 years?

Name of Doctor:	Specialty	Reason:	Date last seen:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Specific wishes for management of terminal illness:

	Yes	No
Do you know what a living will is?	☐	☐
Do you have specific wishes regarding your medical care during a terminal illness?	☐	☐
If yes, what are they?		
Do you have a living will?	☐	☐
Do you want to sign a living will	☐	☐

PREVENTATIVE HEALTH QUESTIONS

Seat Belts:

Do you wear a seat belt?	☐	☐
Do you know that wearing a seat belt reduces the chance of death by 25 times in an accident?	☐	☐

Tobacco Use:

Do you smoke?	☐	☐
How much do you smoke per day? _____		
What do you smoke? _____		
If you've quit smoking, when did you quit? _____		
How much did you smoke before quitting? _____		
How long did you smoke before quitting? _____		
Do you know smoking can cause heart disease, cancer, and emphysema?	☐	☐
If you smoke, do you want to stop?	☐	☐
Do you dip snuff or tobacco?	☐	☐
Do you know that chewing/dipping tobacco can also cause cancer	☐	☐
How many cans per week? _____		

Exercise:

	Yes	No
Do you exercise enough to need a shower after?	☐	☐

What form of exercise do you get? (Mark your choice)

☐**Walking** ☐**Running** ☐**Jogging** ☐**Aerobics** ☐**Biking** ☐**StairMaster** ☐**Weights**

How many times a week? _____

Duration of session? _____

Do you have access to or own any exercise equipment at home or work?	☐	☐

If yes, what kind of equipment?

Cholesterol

Do you know your cholesterol and/or triglyceride levels?	☐	☐
Do you know that high levels of lipids cause?		
Heart Attack	☐	☐
Stroke	☐	☐
Poor circulation in your legs and feet	☐	☐

Salt

Do you add salt in your cooking?	☐	☐
Do you have salt at the table?	☐	☐
Do you eat foods with visible salt?	☐	☐
Do you eat canned foods?	☐	☐
Have you been instructed in a low-sodium diet because of blood pressure or kidney problems?	☐	☐

Fiber

How often do you eat fresh fruits and vegetables per week? _____

What types of fruits/vegetables?

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Glaucoma

Have you had a glaucoma (eye pressure) in the last year. Yes ☐ No ☐

What was the result? _____

What is the name of your eye doctor? _____ Ph: _____

Vaccines:

Have you had the following vaccines? If so, when?

PNEUMOVAX – 23 VALENT	Yes ☐	No ☐	Date _____
PREVNAR-13 – 13 VALENT	Yes ☐	No ☐	Date _____
TDAP (TETANUS, DIPTHERIA, PERTUSSIS)	Yes ☐	No ☐	Date _____
TETANUS ONLY	Yes ☐	No ☐	Date _____
HEPATITIS A	Yes ☐	No ☐	Date _____
HEPATITIS B	Yes ☐	No ☐	Date _____
FLU VACCINE	Yes ☐	No ☐	Date _____
MENINGOCOCCAL	Yes ☐	No ☐	Date _____
MMR (MEASLES, MUMPS, RUBELLA)	Yes ☐	No ☐	Date _____
HUMAN PAPILLOMA VIRUS (GARDASIL)	Yes ☐	No ☐	Date _____
SHINGLES	Yes ☐	No ☐	Date _____
COVID-19			
WERE YOU BORN IN 1957 OR LATER?	Yes ☐	No ☐	
ARE YOU AN INTERNATIONAL TRAVELER?	Yes ☐	No ☐	

BREAST CANCER: LADIES ONLY: If you are over 40 and/or 35 or more if you have a blood relative with breast cancer, the American Cancer Society recommends an annual mammogram to detect early breast cancer.

Do you have a family history of breast cancer? Yes ☐ No ☐

Would you like us to help you schedule your mammogram? Yes ☐ No ☐

When was your last mammogram? _____/_____/_____

PROSTATE HEALTH: GENTLEMEN ONLY: Do you have a urologist or primary doctor who does PSA blood tests on you? Yes ☐ No ☐

When was last PSA test performed? _____/_____/_____

COLORECTAL CANCER: If you are over 45, the American Cancer Society recommends a colonoscopy. When was your last colonoscopy? _____

When is the next one due? _____

Who is your gastroenterologist? _____

SKIN CANCER:

Are you out in the sun often? Yes ☐ No ☐

Do you use at least sun protection factor 15 lotions to prevent burn? Yes ☐ No ☐

Do you have a history of sun-induced skin cancer? Yes ☐ No ☐

Do you have a dermatologist? Yes ☐ No ☐

Name: _____ Phone: _____

DOMESTIC VIOLENCE:

Have you ever felt threatened at home? Yes ☐ No ☐

Have you been physically, verbally or sexually abused by a parent, relative, spouse or acquaintance? Yes ☐ No ☐

Finally, do you have any other questions or comments about **PREVENTATIVE HEALTH** for me today? Yes ☐ No ☐

What are your questions?

Any Comments?