


C O - E D
CENTRAL OKLAHOMA  **EARLY DETECTION**
CENTER
ADVANCED LIPIDOLOGY
CARDIOMETABOLIC RISK
OBESITY

1227 E. 9th Street Edmond, OK 73034 Phone: (405) 475-0100 Fax: (405) 475-9275 <https://susandimickmd.com>

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 the 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 gives 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 hospitalizations and 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 _____ Last year you completed in school _____

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:
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

Specific wishes for management of terminal illness:

	<u>Yes</u>	<u>No</u>
Do you know what a living will is?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have specific wishes regarding your medical care during a terminal illness?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what are they? _____		
Do you have a living will?	<input type="checkbox"/>	<input type="checkbox"/>
Do you want to sign a living will	<input type="checkbox"/>	<input type="checkbox"/>

PREVENTATIVE HEALTH QUESTIONS

Seat Belts:

Do you wear a seat belt?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know that wearing a seat belt reduces the chance of death by 25 times in an accident?	<input type="checkbox"/>	<input type="checkbox"/>

Tobacco Use:

Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
If you smoke, do you want to stop?	<input type="checkbox"/>	<input type="checkbox"/>
Do you dip snuff or tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know that chewing/dipping tobacco can also cause cancer	<input type="checkbox"/>	<input type="checkbox"/>
How many cans per week? _____		

Exercise:

	<u>Yes</u>	<u>No</u>
Do you exercise enough to need a shower after?	<input type="checkbox"/>	<input type="checkbox"/>
What form of exercise do you get? (Mark your choice)		
<input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Jogging <input type="checkbox"/> Aerobics <input type="checkbox"/> Biking <input type="checkbox"/> StairMaster <input type="checkbox"/> Weights		
How many times a week? _____		
Duration of session? _____		
Do you have access to or own any exercise equipment at home or work?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what kind of equipment? _____		

Cholesterol

Do you know your cholesterol and/or triglyceride levels?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know that high levels of lipids cause?		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation in your legs and feet	<input type="checkbox"/>	<input type="checkbox"/>

Salt

Do you add salt in your cooking?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have salt at the table?	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat foods with visible salt?	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat canned foods?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been instructed in a low-sodium diet because of blood pressure or kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>

Fiber

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

What types of fruits/vegetables?

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	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, DIPHTHERIA, 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 _____

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 50, the American Cancer Society recommends a colonoscopy. If you have bowel habit changes or a family history of colon cancer, you should have a colonoscopy every 10 years. You should also do 3 Hemoccult blood detection cards yearly. Would you like us to help you schedule a colonoscopy?

Yes

No

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? _____

