

**Andrews Institute Physical Medicine
Huaiyu Tan, M.D., Ph.D.**

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Pensacola, FL 32501
Phone: 850.437.8670 • Fax: 850.437.8679

Dear Patient:

In anticipation of your upcoming appointment, we would appreciate your attention to the following information:

- Please complete the following paperwork in its entirety to ensure the most accurate records for our physicians. This includes an up-to-date medication list.
- You must be 15 minutes early with your completed paperwork so that we may verify your insurance, scan your cards, and build your chart in time for your appointment. Please make travel arrangements to be *early* to your appointment.
- If you are late to your appointment, we reserve the right to reschedule. This policy is per our providers to ensure a timely schedule for both the physician and our patients.
- **It is the patient's responsibility to verify that our office is In-Network with their insurance. Please call the "1-800" or Customer Care telephone number on the back of the insurance card as soon as possible to verify this information.**
- If you are to be treated for injuries sustained during a motor vehicle accident, bring your automobile insurance card as well as your health insurance cards.
- Please provide our office any pertinent X-ray, MRI or CT reports. This is immensely helpful to the productivity of your appointment.
- Please keep in mind that an appointment with our office is not a guarantee of narcotics or opiates - regardless if you are currently prescribed these medications by another physician.

Helpful tips for our patients:

- If your X-rays, MRIs, CTs or any other scans were completed in a Baptist Health Care facility - we will have access to those images and reports. You will not need to bring those items. Just kindly inform the front desk at check in, and we will get those items attached to your chart for you.
- If you have additional medical records that you find pertinent to your care in our office, please bring them with you. We will be glad to add them to your records. **"We are happy to schedule you as a new patient with Dr. Tan. Please be advised Dr. Tan will not prescribe narcotic medications on your first visit and he will evaluate you to determine if narcotic medications are appropriate during your appointment. We look forward to meeting you at your upcoming appointment. Thank you for choosing Andrews Institute Physical Medicine."**

ANDREWS INSTITUTE PHYSICAL MEDICINE

DEMOGRAPHICS

Please Print

PATIENT NAME _____
SS# _____ BIRTH DATE _____ SEX: MALE FEMALE
ADDRESS _____
CITY _____ STATE _____ ZIP: _____
HOME# _____ CELL# _____ WORK# _____
MARITAL STATUS: _____ DATE OF INJURY IF APPLICABLE _____
EMAIL ADDRESS _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ NUMBER: _____ RELATIONSHIP _____

GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME _____ RELATIONSHIP TO PATIENT: _____
SS# _____ DATE OF BIRTH _____
ADDRESS: _____
HOME# _____ CELL# _____

PATIENT INFORMATION:

HEALTH INSURANCE AUTO INSURANCE WORKERS COMP SELF PAY

PRIMARY INSURANCE

TYPE: _____ INSURED'S NAME _____
INSURED'S DATE OF BIRTH _____
POLICY# _____ GROUP# _____
CLAIM# _____
ADJUSTORS NAME, NUMBER AND FAX _____

SECONDARY INSURANCE

TYPE _____ INSURED'S NAME _____
INSURED'S DATE OF BIRTH _____
POLICY# _____ GROUP _____

I agree to pay for Medical Services rendered at Andrews Institute Physical Medicine. I understand that there are payment plans available at my request. I am responsible for any balance that my Insurance Company does not pay.

X _____ DATE _____

Release of Information: I authorize Andrews Institute Physical Medicine to release medical information requested by health insurance, Medicare, or Third Party payers in order to assist in the payment of claims.

X _____ DATE _____

I authorize the following to pick up medical records, prescriptions, letters, or other documents pertaining to me and my care.

NAME _____ RELATIONSHIP _____

Please note, unless otherwise indicated, copies of your medical records will be sent to your Primary Care Physician and Referring Doctor.

Please Print

Today's Date: _____
(This form is good for 1 year from above date).

TEMP: _____ BP: _____
HT: _____ P: _____
WT: _____ R: _____
BMI: _____

NEW PATIENT HISTORY AND PHYSICAL FORM
(For new patients and to be updated annually)

PATIENT'S NAME: _____ **AGE:** _____

CHIEF COMPLAINT: (Why you are here today) _____

HISTORY OF PRESENT ILLNESS:

Location of pain / problem? _____

How long have you had this problem? _____

How did the problem **start**? _____

How often do you have the pain? _____

What makes it **worse**? _____

What makes it **better**? _____

What **associated problems** have you been having? _____

What is the **severity** of your pain? Mark an **X** on the appropriate circle below

(No Pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (Extreme Pain)

What does the pain feel like? (Throbbing, shooting, sharp, etc.) _____

GENERAL MEDICAL INFORMATION:

My general health is: (Please check one) Excellent Very good Good Fair

Who is your family doctor: _____ **Date of last visit:** _____

Are you pregnant or attempting to get pregnant Yes No

List any medications you are currently taking including strength and how taken:

Name:	Dosage:	How Often:	Name:	Dosage:	How Often:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? Yes No
If yes, write the name of the pills/ supplement and date last taken: _____

ALLERGIES:

List medications and / or foods that you are ALLERGIC to or have had a bad reaction to: _____

What kind of reaction did you have?

Please Print

PAST MEDICAL HISTORY:

Check any problem you have ever been treated for and indicate the year of treatment:

- | | | | |
|-----------------------------------------------|------------------------------------------------------|---------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Cancer: Type_____ |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Hereditary Defects |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Brittle Bones | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Drug Dependency / Alcoholism |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Ruptured Disc | <input type="checkbox"/> Stroke | <input type="checkbox"/> Polio | <input type="checkbox"/> Convulsions / Seizures |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Asthma | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> COPD | <input type="checkbox"/> Thyroid Problems |
| | | <input type="checkbox"/> GERD | <input type="checkbox"/> High Cholesterol/Triglycerides |

SURGICAL / HOSPITALIZATION HISTORY:

PRIOR SURGERIES:

Type of Surgery

Date of Surgery

_____	_____
_____	_____
_____	_____
_____	_____

PRIOR NON-SURGICAL HOSPITALIZATIONS, MAJOR ILLNESSES OR INJURIES:

REASON FOR ADMIT

Date of Admit

_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: S M W DV SP

Are you working now? _____ If no, when did you last work? _____

Place of birth: _____ Grade of school completed: _____

I live in a: House Apartment Condominium Mobile Home Boat

My home is a: Single level Multi-level # of stairs to enter: _____ Inside stairs: _____

I live: Alone with spouse with parents with children Other _____

Current Alcohol Consumption:

Type: Beer Wine Whiskey None

Frequency: Daily Weekly Monthly Never

If you have quit, how long? _____

Current Tobacco Use:

Type: Cigarettes Pipe Chew None

How much used daily? _____

and for how long? _____

If you have quit, how long? _____

Please Print

FAMILY HISTORY:

Mother: Living: YES or NO Age: _____ Condition of health: _____
If deceased, cause of death and age at death: _____

Father: Living: YES or NO Age: _____ Condition of health: _____
If deceased, cause of death and age at death: _____

Have you or any member of your family ever had? (Indicate relative by placing a letter next to problem):
F-(father), M-(mother), GF-(grandfather), GM-(grandmother), B-(brother), S-(sister), C-(Child), U-(uncle), A-(aunt)

- | | | |
|-----------------------|---------------------------|--------------------------|
| _____ CANCER | _____ HIGH BLOOD PRESSURE | _____ HEART DISEASE |
| _____ HEART ATTACK | _____ DIABETES | _____ STROKE |
| _____ ARTHRITIS | _____ SEIZURES | _____ TUBERCULOSIS (TB) |
| _____ KIDNEY PROBLEMS | _____ HEPATITIS | _____ ASTHMA |
| _____ EMPHYSEMA | _____ COPD | _____ LUPUS |
| _____ HIV/AIDS | _____ OSTEOPOROSIS | _____ REACTION TO ANESTH |
| _____ LUNG PROBLEMS | _____ BACK INJURY | _____ STOMACH PROBLEMS |
| _____ ULCERS | _____ DEPRESSION | _____ SKIN BREAKDOWN |

SYMPTOM / SYSTEMS REVIEW:

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GENERAL HEALTH

CONSTITUTIONAL SYMPTOMS

- Fatigue
- Difficulty sleeping
- Unexplained bleeding
- Fever/Chills
- Night sweats
- Recent weight change
- Other _____

NO PROBLEMS

HEAD/FACE

- Headaches
- Lesions or scars
- Reduced facial strength
- Recent hair loss
- Masses
- Facial paralysis
- Scalp tenderness
- Other _____

NO PROBLEMS

EYES

- Blurred or double vision
- Dryness
- Redness of the eyes
- Visual disturbances
- Wear glasses or contacts
- Cataracts
- Glaucoma
- Other _____

NO PROBLEMS

EARS / NOSE / MOUTH / THROAT

- Earaches or drainage
- Bad breath or bad taste
- Bleeding gums
- Hearing loss
- Mouth sores/ulcers
- Frequent sore throat
- Ringing in the ears
- Difficulty swallowing
- Voice changes
- Sinus infections/problems
- Dryness of the mouth
- Sinus tenderness
- Nosebleeds
- Hay fever
- Dentures
- Other _____

NO PROBLEMS

NECK

- Masses
- Tenderness
- Thyroid tenderness
- Vein distension
- Swollen glands in the neck
- Pain
- Other _____

NO PROBLEMS

CHEST / BREAST

- Breast discharge
- Breast implants
- Breast lump
- Breast pain
- Other _____

NO PROBLEMS

CARDIOVASCULAR

- Chest pain or pressure
- Blood clots
- Swelling of feet or ankles
- Fast or irregular heart beat
- Palpitations
- Swelling of the hands
- Heart trouble
- Leg cramps
- Poor circulation
- Other _____

NO PROBLEMS

RESPIRATORY

- Wheezing
- Chronic or frequent coughs
- Cough / mucous production
- Difficulty breathing
- Dry cough
- Shortness of breath/lying flat
- Shortness of breath/walking
- Pain on breathing
- Spitting/coughing blood
- Other _____

NO PROBLEMS

SYMPTOM / SYSTEMS REVIEW: (continued)

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GASTROINTESTINAL

- Heartburn or indigestion
- Changes in bowel movements
- Rectal bleeding or blood in stool
- Painful bowel movements
- Constipation
- Loss of appetite
- Nausea or vomiting
- Abdominal pain
- Frequent diarrhea
- Other _____
- NO PROBLEMS**

GENITOURINARY

- Burning or painful urination
- Blood or pus in urine
- Vaginal discharge
- Incontinence or dribbling
- Pain with periods
- Sexual difficulty
- Genital rash or ulcers
- Irregular periods
- Testicular pain
- Change in force or strain urinating
- Prostate problems
- Other _____
- NO PROBLEMS**

LYMPHATIC/HEMATOLOGIC

- Bleeding or bruising tendency
- Enlarged glands
- Phlebitis
- Slow to heal after cuts
- Other _____
- NO PROBLEMS**

MUSCULOSKELETAL/EXTREMITIES

- Back pain
- Cold extremities
- Difficulty climbing stairs
- Joint pain
- Joint stiffness or swelling
- Numbness or tingling
- Paralysis
- Walk with a limp
- Walk with assistive device
- Walk only limited distances
- Weakness of muscles or joints
- Other _____
- NO PROBLEMS OTHER THAN**

REASON FOR VISIT

NEUROLOGICAL/PSYCHIATRIC

- Convulsions or seizures
- Frequent/recurring headaches
- Numbness or tingling sensation
- Tremors
- Memory loss or confusion
- Light headed
- Loss of consciousness
- Feeling blue
- Dizziness
- Other _____
- NO PROBLEMS**

INTEGUMENTARY / SKIN

- Change in skin color
- Change in hair or nails
- Psoriasis
- Rash or itching
- Skin nodules or bumps
- Other _____
- NO PROBLEMS**

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

I hereby attest that I personally completed this form and all the information is true and correct:

Signature of Patient or Guardian completed form: _____

Date: _____

HISTORY FORM REVIEWED BY: _____

Date: _____

Physician's or Physician Assistant's Signature

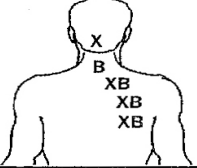
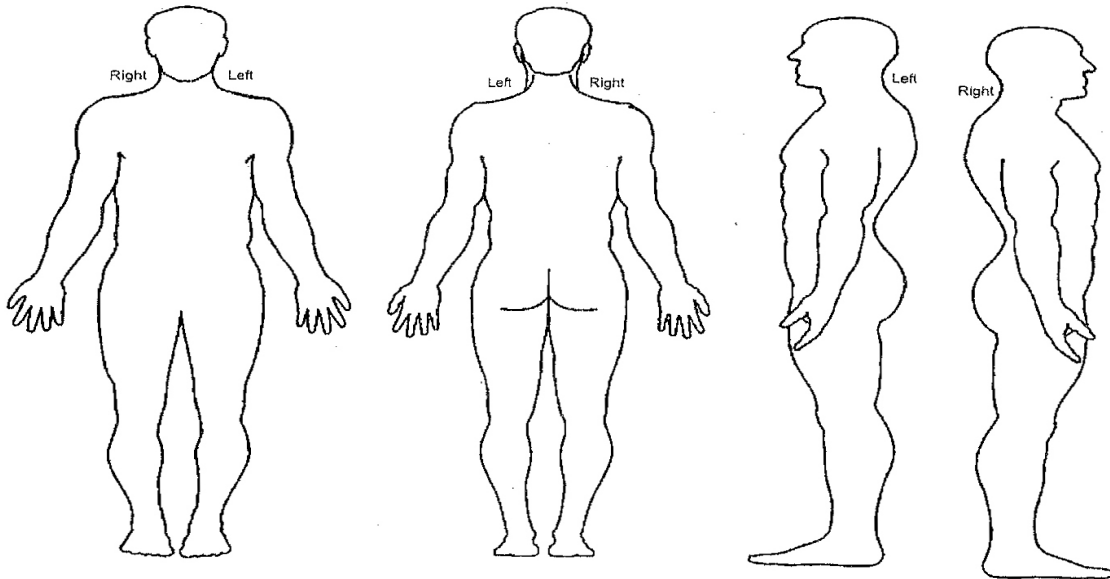
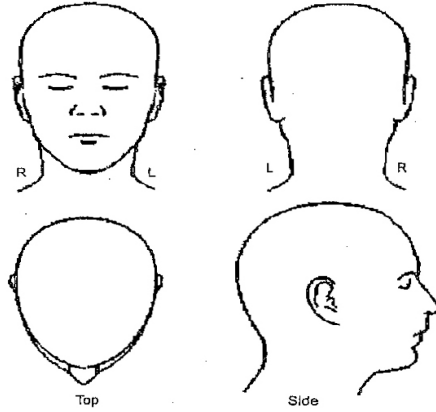
Please use the following symbols to indicate the type and location of your pain on the drawings below.

TYPE OF PAIN	SYMBOL
Sharp	X
Shooting	→
Burning	B
Aching	A
Spasming	S
Tingling	T
Numbness	N

EXAMPLE:

Type of pain:
sharp and burning

Location of pain:
back of neck down
to right shoulder blade

Notice of Privacy Practices: I am aware that Andrews Institute Physical Medicine Group has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policy. I understand that a copy is available to me and I agree with these privacy policies.

Patient's Signature _____