Lake Internal Medicine Associates
Steven M. Tang, M.D.

(352) 589-4774
www.steventangmd.com

2101 Prevatt Street
Eustis, Florida 32726

Your Full Name: _____ Date: _____

Your email address: _____

Current Occupation: _____

Previous Occupations: _____

Other states and countries lived in: _____

Last medical attention date: _____ Physician: _____

Referral source (name): _____

Last Primary Care Physician: Name/Address: _____

Please list all symptoms of present medical problems and reason for visit:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list all Current Medications - Prescription and non-prescription

Doseage and Frequency are a MUST!

If more room is needed, continue on the last page.

Name	Dose	How Often	Name	Dose	How Often
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Patient Name_____

Please list all Allergies (Do not include seasonal allergies)

If more room is needed, continue on the last page.

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Current and Past Medical History (check all that you have or have had):

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer: Location/Date _____
- ☐ Chronic Pain
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hay Fever/Seasonal Allergies
- ☐ Heart Attack (MI): Year-_____
- ☐ Heart Disease
- ☐ Hepatitis: A B C
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Malaria
- ☐ Meningitis: Viral Bacterial
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Stroke/TIA: Year-_____
- ☐ Tuberculosis
- ☐ Ulcer(s)
- ☐ Venereal Disease
- ☐ *Chicken Pox*
- ☐ *Croup (Whooping Cough)*
- ☐ *Dyptheria*
- ☐ *Measles*
- ☐ *Mumps*
- ☐ *Polio*
- ☐ *Scarlet Fever*
- ☐ *Small Pox*
- ☐ *Typhoid Fever*

☐ Other (list): _____

_____

_____

Surgical History:

If more room is needed, continue on the last page.

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

Patient Name_____

Previous Fracture(s) History with dates:

If more room is needed, continue on the last page.

Location	Date	Location	Date
1.		3.	
2.		4.	

Screening / Testing History

	Date		Date		Date
☐ AAA Scan		☐ DXA		Males	
☐ Cardiac Cath		☐ ECG		☐ PSA	
☐ Carotid Ultrasound		☐ Echo			
☐ Chest X-Ray		☐ PFT		Females	
☐ Cholesterol Blood Test		☐ Sleep Study		☐ Mammo	
☐ Colonoscopy		☐ Stool Test		☐ PAP	
		☐ Stress Test			

Vaccination History

Place a check mark next to the vaccines you have had and then list the most recent date received.

	Date		Date
☐ Flu (Influenza)		☐ PPD (Tuberculosis)	
☐ Hepatitis B		☐ Shingles	
☐ Pneumonia		☐ Tetanus (TD)	

Social/Personal History

If more room is needed, continue on the last page.

Coffee: ☐ Yes ☐ No cups per day_____ Tea: ☐ Yes ☐ No cups per day _____

Smoking:

	Current	*Former*	PPD:	Year started:	Year quit:	Total Years Smoked
Cigarettes	☐	☐				
Cigars	☐	☐				
Pipes	☐	☐				
Chewing Tobacco	☐	☐				

Never Smoker ☐

Alcoholic Beverages: ☐ Yes ☐ No ☐ Don't drink Glasses/servings per week: _____

Type (circle): Beer Wine Liquor

Have you been treated for alcoholism in the past? ☐ Yes ☐ No ☐ N/A When: _____

Do you get regular exercise? ☐ Yes ☐ No Type (circle): Cardio Weight-bearing

How often: _____

Patient Name_____

Family History:

Mother: ☐ Living ☐ Deceased Current Age or Age at Death: _____

Cause of Death: _____

Other Relavent Medical Conditions: _____

_____

Father: ☐ Living ☐ Deceased Current Age or Age at Death: _____

Cause of Death: _____

Other Relavent Medical Conditions: _____

_____

Please list all blood-related Brothers and Sisters

If living, give age; if deceased, please list age at death and cause of death. If living, please list relevent medical history/conditions. One sibling per number. Additional siblings may be listed on the last page.

	Name	Age	Sex	Status	Relevant Medical Conditions/History
1.			M F	Living Deceased	
2.			M F	Living Deceased	
3.			M F	Living Deceased	
4.			M F	Living Deceased	
5.			M F	Living Deceased	
6.			M F	Living Deceased	

Please list all blood-related Children

If living, give age; if deceased, please list age at death and cause of death.

	Name	Age	Sex	Status	Relevant Medical Conditions/History
1.			M F	Living Deceased	
2.			M F	Living Deceased	
3.			M F	Living Deceased	
4.			M F	Living Deceased	
5.			M F	Living Deceased	
6.			M F	Living Deceased	

Patient Name_____

Body System Problems

This page is listed by individual body systems. Please **CIRCLE** all problems in each system that apply to you. Within each system, please list any additional problems you have that are not listed.

HEAD: Frequent headaches Migraine headaches Dizziness Seizures

Other: _____

EARS: Deafness Ear infections Frequent ringing in ears Hearing aid(s)

Other: _____

EYES: Glasses Double vision Blurred vision Itchy eyes Eye pain Blindness Spots before eyes

Other: _____

NOSE: Sinusitis Hay fever Frequent colds Post nasal drip Loss of smell Runny nose

Other: _____

THROAT: Frequent sore throat Strep throat Chronic hoarseness Difficulty swallowing Painful swallowing

Other: _____

METABOLIC: Recent weight loss Recent weight gain Increased sweating Fatigue Sugar in urine Frequent urination Fatigue Excessive thirst

Other: _____

RESPIRATORY: Chronic cough (how long_____) Coughing blood Short of breath Wheezing

Other: _____

CARDIOVASCULAR: Chest pain Swelling ankles Heart murmur Rheumatic fever Palpitations High blood pressure Fainting spells Low blood pressure Lightheadedness

Other: _____

GASTROINTESTINAL: Recurrent abdominal pains Gallstones Vomiting Vomiting blood Constipation Bloody Stools Black stools Recurrent diarrhea Cirrhosis of liver Jaundiced Heartburn Hernia Loss of appetitie

Other: _____

G.U.: Kidney infection Bladder infection Blood in urine Urinary dribbling Painful urination Decreased force of urinary stream Frequent urination Kidney stones Decreased sexual drive Prostate trouble Menstrual problems Date of last period:_____ Duration: _____ Vagnial discharge Vaginal irritation

Other: _____

Patient Name_____

MUSCULAR / SKELETAL: Painful joints Leg cramps Muscle cramps Back pain Swollen joints Stiffness

Other: _____

NEUROLOGICAL: Paralysis Numbness Tingling Loss of balance Weakness Slurred speech Loss of vision Difficulty walking

Other: _____

PSYCHOLOGICAL: Crying spells Nervous breakdown Anxiety Excessive worry Insomnia Depression Drowsiness

Other: _____

HEMATOLOGY: Enlarged lymph glands Excessive bleeding after cuts Increased bruising

Blood transfusions: When?_____ How many?_____For what? _____

Other: _____

Information Continuation

Use this space to add any additional information that did not fit in any of the previous sections

_____

_____

_____

_____

_____

_____

Please remember to do the following prior to your appointment:

Do not wear <u>any</u> perfume, cologne, aftershave, scented lotions, etc., to this visit or any future visits.

1. Make a list of all the items you would like to discuss with the doctor at your appointment
2. Bring all of your medications (prescription and non-prescription) with you to your first and all future appointments in their appropriate bottles.
3. These forms must be filled out completely and returned at the time of your first appointment. Completely filling out these pages ensures that you receive the best care possible.
4. Please bring your living will, health care surrogate, and/or power of attorney, if applicable, to your first appointment.
5. Bring all of your insurance cards: they must have the ID number and claims mailing address on them.
6. Bring a valid photo ID; such as a state issued ID card/driver's licence, VA ID card, etc.

PLEASE COMPLETE ALL QUESTIONS. PLEASE **PRINT**.

NAME: _____ DATE: _____

Florida Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Spouse/Significant Other's Name: _____ Relationship: _____

Spouse/Significant Other's Home Phone: _____ Cell Phone: _____

Northern Street Address: _____

City: _____ State: _____ Zip Code:_____ Phone: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Date of Birth: _____ Marital Status: _____

Social Security #: _____Medicare #:_____

Employer Name and Address: _____

Employer Phone: _____ May we contact you at work?_____

Party Responsible for Payment: _____ Relationship to You: _____

EMERGENCY CONTACT INFORMATION: This person is for emergency contact when you and/or your spouse/significant other cannot be reached. **THIS PERSON SHOULD NOT LIVE WITH YOU OR SHARE A PHONE NUMBER WITH YOU.**

Name: _____ Relationship to You: _____

Complete Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Lake Internal Medicine Associates
Steven Tang, M.D.
2101 Prevatt Street
Eustis, Fl. 32726
(352) 589-4774

LIFETIME MEDICARE AUTHORIZATION

PATIENT'S NAME: _____

PATIENT'S MEDICARE NUMBER: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Steven Tang, M.D. for any services furnished to me by Steven Tang, M.D. I authorized any holder of medical information about me to release to the HealthCare Finance Administration and its agents any information needed to determine these benefits.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible and co-insurance and noncovered services. On assigned Medicare cases the Medicare benefits will be sent directly to Steven Tang, M.D.

_____ _____
PATIENT SIGNATURE DATE

LIFETIME AUTHORIZATION FOR:
COMMERCIAL INSURANCE -- MEDICARE SUPPLEMENTS -- CHAMPUS

PATIENT'S NAME: _____
NAME OF MEDIGAP INSURANCE COMPANY IF APPLICABLE AND EFFECTIVE DATE: _____

I request that payment of all authorized benefits be made either to me or on my behalf to Steven Tang, M.D. for any services furnished to me by Steven Tang, M.D. I authorized any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If payment has been made by me for this claim benefits should be sent to me; but medical information necessary to process this claim may be released to my insurance agency.

_____ _____
PATIENT SIGNATURE DATE

Lake Internal Medicine Associates
Steven M. Tang, M.D.
2101 Prevatt Street
Eustis, Florida 32726
(352) 589-4774

Patient Email Documentation

The following information applies to Email communication with Lake Internal Medicine Associates:

1. The office will not communicate any HIPAA protected information via regular email. This may include, but not be limited to, the following types of items:
   - Office progress notes
   - Consultation reports
   - Lab reports
   - Xray reports
   - Prescription information

2. The office may communicate non-HIPAA protected information via regular email. This could include items such as:
   - Notification to check the Patient Portal
   - Patient educational material or links to educational material
   - Notification for general information such as: Flu shots are available

3. Patients will not be able to communicate with the office through regular email. You can communicate with the office by message through our patient portal.

4. It will be the responsibility of the patient to notify the office if your email address is discontinued or changed.

Please PRINT your email address: _____

_____
Patient Printed Name

_____ _____
Patient Signature Date