JSA Medical Group

Sanjay K. Madan MD PA
Practitioner Assessment and Insurance Information

Please complete the following form and bring it with you to your first appointment-- your doctor will need to review your health risk assessment.

JSA Medical Group

GENERAL INFORMATION:

_________________________________ _________________________ ______ _____/___/_____
Patient Last Name First Name MI DOB

_(_______)___________________________ _(______)__________________________________
Home # Cell Phone #

____
Home Address City State Zip

SS#: __________ - ________ -___________ Male Female (Please Circle) Single Married Divorced Widowed (Please Circle One)

____
Employer

____ ______________________________
Primary Insurance Carrier Policy ID

HMO PPO POS Other ______________ (_____)___________________________
(Type of Plan) Insurance Carrier Phone #

____ ______________________________
Second Insurance Carrier Policy ID

HMO PPO POS Other ______________ (_____)___________________________
(Type of Plan) Insurance Carrier Phone #

IMPORTANT: In case of emergency, who would we contact?

____ ____
Name Relationship

____ _(______)________________________________
Address (Street/City/Zip) Home Phone #

__(_______)______________________________ __(______)______________________________
Cell Phone # Work #

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give JSA Medical Group consent to perform medical treatment."

____ ________________
Patient/Guardian Signature Date

Patient Medical History

Patient Last Name: ____________________ Patient First Name:___________________ D.O. B_______________
Date of last physical exam: ______________ Previous Physician Name: ________________________________
Physician Address: ____

PAST HISTORY (Personal and Allergies): Have you had any of the following illnesses?

	Yes	No
Amputation	☐	☐
Anemia	☐	☐
Alcohol Overuse	☐	☐
Allergies (other than medications)	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bleeding Disorder	☐	☐
Cancer location__________________	☐	☐
Cardiac Arrhythmias Pacemaker ________________	☐	☐
Chicken Pox	☐	☐
Colitis	☐	☐
Depression	☐	☐

	Yes	No
CVA/TIA	☐	☐
Diabetes	☐	☐
Emphysema/COPD	☐	☐
Falls	☐	☐
Gallbladder Disease	☐	☐
Gout	☐	☐
HIV / AIDS	☐	☐
Heart Attack / MI	☐	☐
Other Heart Disease (CHF / CAD)	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Measles / Mumps	☐	☐

	Yes	No
Migraine Headache	☐	☐
Nervous Breakdown	☐	☐
Ostomies ___________	☐	☐
Paralysis	☐	☐
Rheumatic Fever	☐	☐
Seizures	☐	☐
Sexually Transmitted Diseases	☐	☐
Sickle Cell Anemia	☐	☐
Sleep Disorder	☐	☐
Stomach Ulcers	☐	☐
Thyroid Disease	☐	☐
Vascular Disease	☐	☐

PERSONAL HABITS:

1) Have you ever smoked? ☐Yes ☐No If yes, are you are regular smoker now? ☐Yes ☐No
Have you used chewing tobacco? ☐Yes ☐No If yes, Number of yrs ____ If No, when did you quit? ______ ______

2) Do you regularly drink alcohol: ☐Yes ☐No If yes, how often: ________________________________

3) Have you ever used any of the following: Marijuana☐ LSD☐ Heroin☐ Cocaine☐ Speed☐ Other☐

OPERATIONS: List and indicate approximate year.
____
____
____

SERIOUS INJURIES: List injuries & give approximate dates.
____
____
____

HOSPITALIZATIONS: (Other than operations)
List reasons and approximate dates
____
____
____

DIAGNOSTIC TESTS/EXAMS:

LAST TEST/EXAM	DATE	LOCATION/PROVIDER
EYE EXAM:	________	________
FOOT EXAM:	________	________

IMMUNIZATIONS: (Please give date) Hepatitis B ______________Flu ______________ Polio _____________

Typhoid____________Smallpox___________Tetanus____________Pneumococcal________Chicken Pox _____

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Patient Last Name: ___________________ Patient First Name:__________________ D.O. B_______________

FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters	M F				
	M F				

Check if any blood relative has or had any of the following and enter their relationship:

	Yes	No	Relationship to you		Yes	No	Relationship to you
Arthritis	☐	☐	________________	High Blood Pressure	☐	☐	____________________
Asthma	☐	☐	________________	Intestinal Polyps	☐	☐	____________________
Bleeding Tendency	☐	☐	________________	Kidney Disease	☐	☐	____________________
Cancer	☐	☐	________________	Leukemia	☐	☐	____________________
Colitis	☐	☐	________________	Migraine	☐	☐	____________________
Congenital Heart Disease	☐	☐	________________	Nervous Breakdown	☐	☐	____________________
Diabetes	☐	☐	________________	Rheumatic Fever	☐	☐	____________________
Emphysema	☐	☐	________________	Sickle Cell Anemia	☐	☐	____________________
Epilepsy	☐	☐	________________	Stomach Ulcers	☐	☐	____________________
Goiter	☐	☐	________________	Stroke	☐	☐	____________________
Gout	☐	☐	________________	Suicide	☐	☐	____________________
Hay Fever	☐	☐	________________	Tuberculosis	☐	☐	____________________
Heart Attack	☐	☐	________________	Other	☐	☐	____________________

MEDICATIONS:

- ☐ Asthma Wheezing Medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or Similar Products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or Heart Medicine
- ☐ Hormones
- ☐ Insulin or Diabetic Pills
- ☐ Anemia Medications
- ☐ Laxatives
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach/Digestive Medicine
- ☐ Weight-Reducing Pills
- ☐ Blood Thinners or Coumadin
- ☐ Dilantin or Seizure Medications
- ☐ Water Pills or Diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/Barbiturates
- ☐ Vitamins
- ☐ Other Prescription or Over the Counter Drugs

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Patient Last Name: ___________________ Patient First Name:__________________ D.O. B_______________

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How Often?	When Started?

Are you allergic to any medications: Yes ☐ No ☐ If yes, please list medications and the reactions.

Medication	Reaction

Patient Last Name: ____________________ Patient First Name:___________________ D.O. B________________

Social / Lifestyle History:		Primary Language __________________
Is there someone that lives in your residence?	YES NO	If yes, please list name and relationship:
Type of Residence		Apartment Mobile Home House One Story Two Story Assisted Living Facility Facility Name______________Other______________
Durable Medical Equipment	YES NO	Wheelchair ______________ Oxygen ______________ Walker ______________ Nebulizer ______________ Cane ______________ CPAP/BIPAP ______________ Other ______________
Can you afford medicines?	YES NO	Potential Referral to Patient Assistance Program
Transportation provided by?		
Nutritional History:		
Current Weight _____ **Lbs**		Current Height Weight Changes in the past 6 months? **Yes / No** _____ Ft _____ In
Current Diet Plan		
Exercise / Activity:		
Current Activity		How Often
Physical Limitations:		
Activities of Daily Living:		
Do you require assistance to bathe or groom?	YES NO	If yes, Explain: ____ ____
Do you require assistance for your toilet needs?	YES NO	If yes, Explain: ____ ____
Do you require assistance to eat?	YES NO	If yes, Explain: ____ ____
Do you have hearing loss?	YES NO	Do you wear hearing aids? Yes ☐ No ☐ Last hearing exam date: ______________________

Additional Comments and Notes:

___

___

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Patient Last Name: ___________________ Patient First Name:__________________ D.O. B_______________

Preventative Service History

Preventive Services	Date Rec'd	Findings and Recommendations
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening		Hypercholesterolemia ☐
Cholesterol >>>>>>>>>>>>>>>>>>>>>>>>>>	_______________	Hyperlipidemia ☐
LDL >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	________________	Other ☐ ___________________________
EKG >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	________________	EKG Results:
Colorectal Cancer Screening		
Flexible Sigmoidoscopy>>>>>>>>>>>>>	_________________	
Barium Enema >>>>>>>>>>>>>>>>>>>>>>	_________________	
Colonoscopy (not high risk)>>>>>>>>>	_________________	
Fecal Occult Blood Test>>>>>>>>>>>>>	_________________	
Diabetes Screening		
Hg A1C >>>>>>>>>>>>>>>>>>>>>>>>>	________________	
Foot Exam >>>>>>>>>>>>>>>>>>>>>>>>>	________________	
Eye Exam >>>>>>>>>>>>>>>>>>>>>>>>>	________________	Cataracts ☐ Other ______________________
Glaucoma Screening		Glaucoma ☐
PAP and Pelvic Examination		
Prostate Cancer Screening		
Digital Rectal Exam (DRE)		
Prostate Specific Antigen Test (PSA)		
Mammogram Screening		
Breast Self Exam		
Mammogram		

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Date reviewed Physician Signature

***After review of the Practitioner Assessment please remember to code **99420**