



Patient Information Form

Name: _____
 Date of birth: _____ Age: _____ Last 4 digits of SS#: _____ Married/Single/Divorced/Widowed
 Address: Street: _____ City: _____ State: _____ Zip: _____
 Telephone numbers:
 Home: _____ Cell: _____ Work: _____
 Employer: _____ (If the patient is a minor, list the guardian's employer)
 Employer's address: _____
 Emergency Contact: _____

How did you find out about our office? _____

We are sensitive to your privacy wishes. In the following sections, please help us understand how we may best communicate with you, and how we may communicate about you to other health care providers.

Communication by texting and email is convenient, efficient, and a part of daily life for many people. It is important that you understand that email and text communications between you and us are not encrypted and therefore not secure. If you communicate with us from your workplace computer, your employer and its agents may have access to these communications. Any email communication between you and us may become part of your medical record and be accessible to the office staff as needed.

- Yes, I consent to texting communication with Dr. Kunkel and the office staff
- I understand that I am responsible for providing Dr. Kunkel's office staff of any updates to my email address
- I understand that I may revise or withdraw my consent at any time by notifying the office of this desired change
- No, I prefer not to have email communication
- No, I prefer not to have text communication
- Please list your email address only if you authorize Dr. Kunkel and the office staff to communicate with you by email:

We use an electronic medical record system in the office. To allow more effective coordination of your care with others involved in your care (doctors, hospitals, labs, pharmacies, radiology centers, etc.), the electronic record system may be connected to a secure health information exchange. Please place a check mark in the appropriate box:

- I agree to allow my records to be communicated via the internet secure health information exchange in order to aid in coordinating my care.
- I do not want my records to be communicated via the internet secure health information exchange. I understand that this decision means that information that is important to my care may not be communicated as efficiently.

We also utilize TouchMD in the office. TouchMD is an internet-based company that helps us create a more thorough, complete educational experience. By creating a private, password-protected account with TouchMD, you can access diagrams and videos of procedures that are of interest to you. Photographs that we take of you are sent electronically to TouchMD, which then allows you to view the photos in the comfort of your own home or on your mobile device. Please check the appropriate box:

- I agree to use the TouchMD service, allowing me to view diagrams, videos, and my photographs through a password-protected internet connection created by TouchMD.
- I do not want to participate in the use of the TouchMD service. I do not wish to see additional videos or diagrams or my photographs through this system.

SIGNATURE: _____

DATE: _____



Patient Information Form

Health Information

What is the reason for your visit today? _____

Have you seen another physician related to this concern? If so, who and when? What was done at that time?

Please list other physicians involved in your care:

Primary care physician: _____

Cardiologist: _____

Dermatologist: _____

Other: _____

Ob-gyn physician: _____

List any allergies you have (medications, food, etc.): _____

Have you ever used a nicotine product routinely (cigarettes, e-cigarettes, nicotine gum or patches, Juul)? Yes No

If yes, please describe: _____

Do you drink alcohol? If so, how much and how often _____

What is your approximate height? _____ feet _____ inches

What is your approximate weight? _____ lbs.

Do you take aspirin: daily? Yes No

just for headaches? Yes No

If you take aspirin daily, how much do you take? 'baby' aspirin (81mg) 'regular' aspirin (325 mg)

Please list medications, vitamins and herbal supplements that you take:

<u>Name</u>	<u>Dose</u>	<u>How Often</u>

Check any illnesses or conditions YOU have had:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other lung issue |
| <input type="checkbox"/> Hepatitis/jaundice/liver problems | |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Autoimmune disorder |
| <input type="checkbox"/> Stroke/seizure | <input type="checkbox"/> cancer (list): _____ |

Please mark any operations you have had, and list the approximate year:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart bypass _____ | <input type="checkbox"/> Pacemaker _____ | <input type="checkbox"/> Coronary artery stent _____ |
| <input type="checkbox"/> Hernia repair _____ | <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Gallbladder _____ |
| <input type="checkbox"/> Cesarean section _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Tubal ligation _____ |
| <input type="checkbox"/> Surgery on ovaries _____ | <input type="checkbox"/> Thyroid surgery _____ | <input type="checkbox"/> Prostate surgery _____ |
| <input type="checkbox"/> Weight loss surgery (lap-band, gastric sleeve, gastric bypass) _____ | | |
| <input type="checkbox"/> Skin cancer (describe) _____ | | |
| <input type="checkbox"/> Other surgery _____ | | |

Thank you for your assistance in providing this information!