Michael E. Mandis, MD, LLC
2236 Vadalabene Drive, Suite #2
Maryville, IL 62062
Phone (618)288-6136 Fax (618)288-6143

Name_____ SS#_____

Address_____
Street City State Zip

Date of birth:_____ Marital status:_____ Email:_____@_____ Sex: M F

Employer:_____ Occupation:_____

Race_____ Preferred language_____ Ethnicity_____

How did you hear about our office? _____ Who was your previous doctor?_____
Emergency contact name and phone:_____

Person responsible for account_____ Relation to patient_____

Address:_____ SS#_____

Responsible party phone #_____ Employers name and phone_____

Insurance information
Insurance company_____ ID#_____

Group #_____ Who is the subscriber?_____

Subscriber SS#_____ Subscriber's employer?_____

I certify that I, and/or my dependent(s) have insurance coverage with _____ company and assign directly to Dr. Michael Mandis/Anderson Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of patient or representative Relationship to patient

HEALTH HISTORY

Name_____ Today's date_____

Age_____ Date of birth_____ Date of last physical exam:_____

What is the reason for today's visit?_____

CHRONIC CONDITIONS

Please check if you have or have had in the past

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Arthritis
__Asthma
__Bleeding problems
__Beast lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical dependency
__Chicken Pox
__Diabetes
__Emphysema
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart disease
__Hepatitis-type?__
__Hernia
__Herpes
__High Cholesterol
__HIV positive
__Kidney disease
__Liver disease
__Migraine headaches
__Miscarriage
__Mononucleosis
__Multiple sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__ Prostate problems
__Psychiatric care
__Rheumatic fever
__Scarlet fever
__Suicide attempt
__Thyroid problems
__Tonsillitis
__Tuberculosis
__Typhoid fever
__Ulcers
__Vaginal infections
__Venereal disease

SYMPTOMS

Please check if you are currently having or have had IN THE PAST YEAR

GENERAL

__Chills
__Depression
__Dizziness
__Fainting
__Fevers
__Forgetfulness
__Headaches
__Loss of sleep
__Loss of weight
__Nervousness
__Sweats

MUSCULOSKELETAL

pain, weakness in:
_arms _hips
_back _legs
_feet _neck
_hands _shoulders

GU

__Blood in urine
__Frequent urination
__Lack of bladder control
__Painful urination

Gastrointestinal

__Appetite poor
__Bloating
__Bowel changes
__Constipation
__Diarrhea
__Excessive hunger
__Excessive thirst
__Gas
__Hemorrhoids
__Indigestion
__Rectal bleeding
__Stomach pain
__Vomiting
__Vomiting blood

Cardiovascular

__Chest pain
__High blood pressure
__Irregular heart beat
__low blood pressure
__Poor circulation
__Rapid heart beat
__Swelling of ankles
__Varicose veins

EENT

__Bleeding gums
__Blurred vision
__Crossed eyes
__Difficulty swallowing
__Double vision
__Earache
__Ear discharge
__Hay fever
__Hoarseness
__Nosebleeds
__Persistent cough
__Ringing in ears
__Sinus problems
__Vision – flashes
__Vision-halos

SKIN

__Bruise easily
__Hives
__Itching
__Change in moles
__Rash
__Sore that won't heal

MEN

__breast lump
__Erection difficulties
__Lump in testicles
__Penis discharge
__Sore on penis
__Other

WOMEN

__Abnormal pap
__Bleeding between periods
__Extreme menstrual pain
__Hot flashes
__Nipple discharge
__Painful intercourse
__Vaginal discharge
__Other

Date of last menstrual period_____
Date of last Pap smear_____
Last mammogram_____
Are you pregnant?_____
Number of children_____

HEALTH HISTORY, CONTINUED

Name_____ Today's date_____

Medications

Please list your current medications: Pharmacy?_____

Name of medication dosage how often/when do you take

Are you allergic to any medications or substances? If so, please list here:

Family history

Father's age____ If deceased, age at death_____ Cause of death/significant medical problems_____

Mother's age_____ If deceased, age at death_____ Cause of death/significant medical problems _____

Brothers and sisters – if deceased, cause of death_____. Any significant medical problems?_____

Hospitalizations/Surgeries

Please list any surgeries, serious injuries and illnesses or hospitalizations and the year in which they occoured:

Problem Year

Lifestyle-check if applicable:

__Caffeine- How much/often?_____
__ Tobacco-packs per day?_____ Years you have smoked_____ If quit, year quit?_____
__ Drugs- what type?_____
__Other_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any other members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Michael E. Mandis, MD
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Authorization of Communication to designee(s)

Patient name:_____ Date of birth:_____

Social security#_____-____-_____
Address:_____

Release of information to family, friends and/or caregivers. Our practice may release your Protected Health Information to a person that is involved in your care, or to someone who assists in taking care of you. We may release this Protected Health Information only with a written authorization from you. Please list below the names and information of anyone who may receive your health information.

Designee name_____ Date of birth:_____

Phone#_____ Relationship_____

Designee name_____ Date of birth_____

Phone#_____ Relationship_____

Designee name_____ Date of birth_____

Phone#_____ Relationship_____

I understand that information regarding physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, HIV testing and AIDS diagnosis or treatment must have a separate authorization before this information can be released. I understand that I may revoke this authorization at any time through written notice.

Signature:_____ Date:_____

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I, _____ have received a copy of Dr. Mandis' Notice of Privacy Practices.

_____ _____

Signature of patient Date