Dear New Patient,

Thank you for choosing Missouri Delta Rheumatology!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐ Patient Assessment ☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

Nivedita Nagam, MD
135 Plaza Drive, Suite 102
Sikeston MO 63801
(573) 472-6010
www.missouridelta.com

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON MISSOURI
Patient Assessment

DATE:_____________ NAME: ______________________________ DOB: ___________

Do you have an Advance Directive (i.e. Living Will, Power of Attorney, etc)? Yes No

If yes, which one and do we have a copy? ______________________________________

Please check any immunizations you've had:

Flu Vaccine □ **No** □ **Yes** If yes, when? _________________ Where? □ at MDMC □ other facility

HPV Vaccine □ **No** □ **Yes** If yes, when? ________________ Where? □ at MDMC □ other facility

Pneumonia Vaccine □ **No** □ **Yes** If yes, when? ___________ Where? □ at MDMC □ other facility

TDAP Vaccine □ **No** □ **Yes** If yes, when? ______________ Where? □ at MDMC □ other facility

□ Other: ______________________________________ Where? □ at MDMC □ other facility

Do you smoke? _______ **If yes, how long?** ________ **How many packs per day?** ________

Female
When was your last?
Mammogram? ______________________
Pap Smear? _______________________
Colonoscopy? _____________________

Male
When was your last?
PSA? _______________________
Colonoscopy? _______________________

If Diabetic:
When was your last?
Hgb A1C? ____________ Foot Exam? _____________ Eye Exam _____________

Have you had any visits to the Emergency Room or Hospital stay since your last office visit?

If yes, When? ____________________________ Why? ___________________________

Do you see other physicians/providers besides your Primary Care Physician?

If yes, Name of Provider/Specialty ____________________________

Reason? ____

Are you having any pain? Yes No Please circle the number that describes your pain.

Location: _______________________ 0 1 2 3 4 5 6 7 8 9 10

None mild mod severe very severe worse

Have you had any falls that have resulted in injury in the past year? _________________

If yes, How Many? __________________ Type of injury? ____________________________

Do you have any of the following?

□ CAD (Coronary Artery Disease) □ Diabetes □ Hypertension

What level of education have you completed? ____________________________________

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: ______________________________________

Date:______________________________________

□ Patient was unable /unwilling to sign acknowledgment.

Reason: ____

Staff initials: _____________

Date: __________________

Time: ______________

Below is a list of people that may receive full disclosure of my medical information:

____

____

____

Copy of Notice was included in patient's Admission Information Packet