Midwest Medical Associates

Pandelis Banias PhD, MD.
800 E. Austin Avenue, Evanston, IL. 60202
(847)316-4455 Office (847) 316-4456 Fax

WELCOME TO OUR PRACTICE
Please take a few minutes to answer the following questions. So we can better assist you with your health care needs.

PATIENT INFORMATION
Date _____Soc. Sec. # _____Birthday_____

Name _____ _____ _____
Last Name First Name Initial of Middle Name

Address _____

City _____ State _____ Zip _____

E-mail _____

Cell Phone _____ Home Phone _____

Sex: M F
Minor Single Married Long Term Partner
Divorced Widowed Separated

Employer _____
Business Phone _____
Business Address _____
Occupation _____
Who should we thank for referring you?
_____
In case of emergency, who should we contact? _____
Phone _____

PRIMARY INSURANCE
Person Responsible for Account
_____
Last Name First Name Initial
Relationship to Patient _____ Birth Date _____
Soc. Sec. # _____
Address _____
City _____ State _____
Zip _____
Home Phone _____

Responsible Party Employed By _____
Business Phone_____
Business Address _____
Occupation _____
Insurance Company
_____
Insurance Company Address
_____
Subscriber I.D. # _____
Group # _____

ADDITIONAL INSURANCE
Insured Name
_____
Last Name First Name Initial

Relationship to Patient _____ Birth Date _____
Soc. Sec. #_____
Home Phone _____
Address _____
City _____ State _____
Zip _____

Insured Employed By _____
Business Phone _____
Insurance Company
_____
Insurance Company Address
_____
Subscriber I.D. # _____ Group #
_____

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REASON FOR VISIT
Please list your present health concerns, problems or symptoms:
_____
_____
_____

FAMILY HISTORY
Mother(Please Circle): High blood pressure, heart attack, diabetes, Cancer, Stroke, _____
Father(Please Circle): High blood pressure, heart attack, diabetes, Cancer, Stroke, _____
Siblings(Please Circle): High blood pressure, heart attack, diabetes, Cancer, Stroke, _____
Other Relatives(Please Circle): High blood pressure, heart attack, diabetes, Cancer, Stroke,_____

MEDICAL HISTORY
When was your last physical exam?
_____
Physician's Name: _____
Phone #: _____

1. Are you currently under medical treatment?
   Please describe:_____
2. Have you ever had any serious illnesses or operations? Yes No
   Please describe: _____
3. Are you currently taking any medications? Yes No
   List:_____

4. Do you smoke?.....Yes, if so how much/day_____ No

5. Do you drink alcohol?.....Yes, is so how much/day_____ No

6. Do you use cocaine or other drugs?.....Yes, if so how often?_____ No

7. Have you had any allergic reactions to the following? Please circle….
   a. Pencillin or other Antibiotics……Yes No
   b. Local Anesthetics……Yes No
   c. Barbituates(sleeping pills)……Yes No
   d. Sedatives……..Yes No
   e. Iodine……...Yes No
   f. Aspirin……..Yes No

g. Other…….Yes No

Please describe:_____

Have you ever had the following: Please circle

Anemia(low blood count)	Heart Murmur	Pneumonia
Anorexia(no appetite)	Heart Disease	Polio
Arthritis	Hepatitis-Type	Prostate Problem
Asthma	Hernia	Psychiatric Care
Back Problems	Herpes	Respiratory Disease
Bleeding Tendency	High Blood Pressure	Rheumatic Fever
Blood Disease	HIV/AIDS	Shortness of Breath
Cancer	IBD-(Crohn's or Ulcerative Colitis)	Scarlet Fever
Chemotherapy	Jaundice	Sinus Problems
Chest Pain	Kidney Disease	Chicken Pox
Chronic Kidney Disease	Latex Sensitivity	Skin Rash
Chronic Fatigue Syndrome	Liver Disease	Stroke
Circulatory Problems	Low Blood Pressure	Thyroid Problems
Congenital Heart Lesions	Measles	Tonsillitis
Cough-persistent or bloody	Migraines	Ulcer
Decreased Hearting	Mitral Valve Prolapse	Venereal Disease
Diabetes	Mumps	
Emphysema	Multiple Sclerosis	Any other Disease: _____
Epilepsy	Pacemaker	_____
Glaucoma	Heartburn	