

ARIZONA TELEMEDICINE PROGRAM

PATIENT HISTORY FORM  
FOR NON-INTERNAL MEDICINE CASE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Local MRN: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F  / IP  OP

Type of Teleconsult Requested: \_\_\_\_\_ New  Follow-up

Physician / HCP: \_\_\_\_\_ Dept: \_\_\_\_\_ Facility: \_\_\_\_\_

1) Chief complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Diagnostic or therapeutic question: \_\_\_\_\_  
\_\_\_\_\_

3) Known allergies: \_\_\_\_\_  
\_\_\_\_\_

4) Current medications: \_\_\_\_\_  
\_\_\_\_\_

5) Treatment attempts & results including current treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) Vital signs: HT \_\_\_\_\_ WT \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ RR \_\_\_\_\_ T \_\_\_\_\_

7) Additional notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) Referring physician/HCP name (PLEASE PRINT): \_\_\_\_\_

Referring physician/HCP signature: \_\_\_\_\_

Date and Time: \_\_\_\_\_ (SECTION 8 MUST BE COMPLETED)