Patient Medical History Form

Patient Name _____

Date _____

Who referred you to our office? _____

Who is your Primary Care Doctor? _____

Surgical History (Please list all surgical procedures you have had in the past)

Surgery	Year	Surgeon

Family Medical History (Please check pertinent medical history for the listed family members)

(GM = Grandmother GF = Grandfather)

	Mother	Father	Brother	Sister	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Heart disease								
Cancer								
Diabetes								
Clotting disorders								
Obesity								
Other (list)								

Patient Medical History Form

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Drug Allergies (Provide list of drug allergies and include reaction)

Current Medications (Please list all current medications and supplements with dosages or provide a list)

Medication	Dosage

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Social History

Occupation _____ Marital Status _____

☐ Live alone ☐ Live with others

Tobacco: ☐ Never smoker ☐ Former smoker ☐ Current every day smoker ☐ Current someday smoker

☐ Smoker within last year ☐ Quit date _____

Alcohol: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Recreational Drugs _____ ☐ None ☐ Current ☐ Former

Caffeine: ☐ Occasional ☐ Moderate ☐ Heavy

Special Diet? _____

Exercise: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Dieting History (List **all** diet and exercise attempts within the last 5 years)

☐ Physician supervised weight loss program

☐ Prescription medications

☐ Weight Watchers

☐ Nutri-system

☐ HCG diet

☐ Over the counter medications

☐ Jenny Craig

☐ Exercise/personal trainer

☐ Other _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the Following scale to choose the most appropriate number for each situation.

Scale

0= would never doze

1= slight change of dozing

2= moderate chance of dozing

3= high chance of dozing

Situation	**Chance of dozing (0-3)**
Sitting and reading	
Watching Television	
Sitting inactive in a public place	
As a passenger in a car for an hour without a break	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Add together for **Total Score**	

Score Results

1-6 Congratulations you are getting enough sleep

7-8 Your score is average

9 and up Very sleepy and should seek medical advice

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Medical History (Please check **all** that apply)

General

Functional Status: ☐ Independent ☐ Partially dependent ☐ Totally dependent

Neurologic

☐Seizure ☐Stroke ☐Migraines

Cardiac

☐High Blood pressure ☐History of heart attack ☐Cardiac stents ☐Cardiac Surgery

Vascular

☐Venous stasis ☐Vein thrombosis (DVT) ☐Coumadin ☐IVC Filter

Pulmonary

☐Asthma ☐COPD ☐Oxygen Dependent ☐Pulmonary embolism ☐Sleep apnea ☐CPAP/BiPAP

Gastrointestinal

☐Reflux ☐Hiatal Hernia ☐Stomach Ulcers ☐Fatty Liver Disease

Endocrine

☐Diabetes Mellitus ☐High Cholesterol ☐Hypothyroid

Musculoskeletal

☐Osteoarthritis ☐Rheumatoid Arthritis ☐Back injury ☐Ambulation is limited most or all of the time

Genitourinary

☐Renal Insufficiency ☐Dialysis

Hematologic/Immune/Oncology

☐Anemia ☐Routine Steroid Use or other immunosuppressant ☐ Cancer _____

Psychological

☐Bipolar ☐Eating disorder ☐Substance Abuse ☐Suicide Attempt

Review of Symptoms (Please check symptoms you are **currently** experiencing)

General	**Neurologic**	**Cardiac**	**Pulmonary**
☐Fatigue	☐Headaches	☐Chest Pain	☐Shortness of breath
☐Weight gain/loss	☐Memory Loss	☐Palpitations	☐Chronic Cough
☐Hard of Hearing	☐Numbness	☐Leg swelling	☐Wheezing
Ear/Nose/Throat	☐Weakness		
☐Hard of hearing	**Gastrointestinal**	**Genitourinary**	**Psychiatric**
☐Difficulty swallowing	☐Heartburn	☐Urinary incontinence	☐Depression
Musculoskeletal	☐Abdominal pain	☐Difficult urination	☐Panic attacks/Anxiety
☐Joint/back Pain	☐Nausea/vomiting	☐Urinary frequency	
☐Impaired mobility	☐Diarrhea/Constipation		

1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

3. NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:

I agree and understand that all physicians (including fellows, residents, and interns), dentists, oral surgeons and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions and the Physician Clinic is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Physician Clinic. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Physician Clinic.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Physician Clinic. I understand that one or more physicians, fellows, residents, and/or interns at the Physician Clinic may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

Patient Label

5. ADVANCE DIRECTIVE ACKNOWLEDGEMENT:

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).
☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.
☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. RESEARCH STUDIES:

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)*
Who can the Physician Clinic contact with questions about the Study? _____ .

7. CONSENT TO PHOTO/VIDEO:

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. E-MAIL:

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

Patient Label

10. CELL PHONES:

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. VIDEOTAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label