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

Patient Name ___________________________

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

Patient Medical History Form

Patient Name _________________________

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 ☐ HCG diet

☐ Prescription medications ☐ Over the counter medications

☐ Weight Watchers ☐ Jenny Craig

☐ Nutri-system ☐ 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

Patient Medical History Form

Patient Name _________________________

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		

STEWARD MEDICAL GROUP

GENERAL CONSENT FOR TREATMENT

AUTHORIZATION FOR TREATMENT:
I voluntarily consent to the rendering of medical care, treatment and diagnosis, including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his or her judgment.

I understand that medical diagnosis and treatment may involve substantial risk. I understand that absent emergency or extraordinary circumstances, major therapeutic and diagnostic procedures will not be performed on me unless or until I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction with my physician or other health care professional and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome from any diagnostic or therapeutic treatment performed on me at the hospital.

Further, I understand and agree that medical, nursing and other health care personnel in training may participate in my care and treatment as part of their education and training unless I request otherwise. I understand that I have the right to refuse or withhold my consent to any proposed diagnostic or therapeutic procedure. I have been afforded the opportunity to set forth below any limitations to the general consent I have granted herein:

USE AND RELEASE OF INFORMATION:
I understand that Steward Medical Group will keep records that contain my medical, personal, and other information related to my diagnosis, care, and treatment in electronic, paper, and other forms. I understand that Steward Medical Group may release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to other health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process insurance claims, for utilization and review, or for billing and collection purposes, as necessary to obtain payment); or (3) for the health care operations of Steward Medical Group or another health care provider that has had a relationship with me (quality assessment, training programs, planning, etc.). This information may include genetic test results or other information as needed for these purposes.

TELEMEDICINE:
I understand that Steward Medical Group may use telemedicine during the course of my care and treatment. Telemedicine uses audio and video equipment to permit a two-way, real-time, interactive communication between a patient and a physician or other practitioner who may be located at a distant site. The information gathered during a telemedicine encounter will be maintained in my medical record, and privacy and confidentiality of my medical information will be maintained at all times. The hospital will not record the actual audio or video transmission unless otherwise specified by my physician or practitioner. I understand that I have the right to withdraw my consent for telemedicine at any time without affecting my right to future care or treatment. I also understand that alternative methods of care may be available to me, and I may choose other options at any time.

ASSIGNMENTS OF BENEFITS:
I hereby assign to Steward Medical Group the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Steward Medical Group. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

FINANCIAL RESPONSIBILITY:

I understand that insurance may not pay the full amount of all my charges and I acknowledge that I am financially responsible and agree to pay my bill for non-covered services, as well as any deductibles, coinsurance or any amounts in excess of insurance benefits. If I am uninsured, I agree to assume full financial responsibility for payment of all charges.

SIGNATURE:

My signature below constitutes my acknowledgement that I have read and understand the above information, that any questions I have asked have been satisfactorily answered, and that I agree to this consent of treatment as described herein.

Patient's Signature: ____ Date: _____________ Time:

Personal Representative: ____ Date: _____________ Time:

Relationship to Patient:____

Witness: ____ Date:_____________ Time:

Interpreter Services Signature: __________________________________ Date:_____________ Time:

ACKNOWLEDGEMENT OF PRIVACY RIGHTS & PRACTICES AND CONSENT FOR COMMUNICATIONS

NOTICE OF PRIVACY RIGHTS & PRACTICES – ACKNOWLEDGEMENT STATEMENT:

I acknowledge that I have received a copy of the Steward Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes the ways in which Steward Medical Group may use and disclose my healthcare information for treatment, payment, and healthcare operations. I understand that I may contact the Privacy Officer identified in the Notice of Privacy Practices if I have questions or a complaint.

Patient's Signature:____ Date: _________________ Time:
(or signature of parent, representative/guardian if applicable)

Staff Use Only:
If unable to obtain acknowledgment, describe your attempt to obtain it and why you were unable to do so:

Staff Signature:____ Date: ________________ Time:

Print Name: ____

CONSENT TO USE OF TEXT MESSAGES

I consent to the receipt of text messages from Steward Medical Group and/or its agents at any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service) I have provided previously or may provide in the future for appointment reminders or to notify me that I need to schedule an appointment or to notify me that test results can be viewed on my secure patient portal. If I do not wish to continue receiving text message reminders I can discontinue this service at any time.

Initials: _________________ Cell Phone Number for Texting: (_______) _______-___________

CONSENT FOR PAYMENT & COLLECTION COMMUNICATIONS:

I agree that Steward Medical Group and its agents, including debt collectors, may contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message, even if I am charged for the call or message, for the purpose of servicing my account and collecting amounts due. I agree that such automated calls may be made to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service) I have provided previously or may provide in the future in connection with my account, unless I have requested confidential communications from Steward Medical Group and its agents or a restriction on the disclosure of my healthcare information in accordance with the Notice of Privacy Practices and Steward Medical Group has agreed to such request. With this consent, I waive any claim I may have against Steward Medical Group and/or its agents, including debt collectors, for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. I also agree that this provision applies to the use of text messaging.

I understand there is a risk of a third-party accessing my health information when communicated over these media. I understand that I am not required to consent to these types of communications and a decision not to sign this consent authorization will not affect my health care in any way. If I prefer not to consent to these communication methods (opt out of receiving prerecorded telephone and text messages), I understand that Steward Medical Group will continue to use U.S. Mail or regular telephone messaging to communicate with me. I have read this consent and agree that Steward Medical Group my contact me as described above.

Patient's Signature:____ Date: ________________ Time: