Rozin Internal Medicine

MUST BE COMPLETED ANNUALLY

Patient Information

Name: ___________________________

Name you like to be called? ______________

Who Referred You: ___________________

Sex: Male Female Date of Birth: ___/___/_____

Social Security #: _____-_____-__________

Street Address: ______________________

City: ____________ State: _____ Zip: ________

Home Phone: _______________________

Cell Phone: ________________________

E-mail Address: _____________________

Single Married Separated Divorced Widowed

Spouse Name: ______________________

Spouse Cell Phone: ___________________

Spouse Work Phone: __________________

Spouse E-mail Address: _______________

Patient Employment

Employed Unemployed Retired Student

Employer: ________________________

Occupation: _______________________

Work Phone: _______________________

Business Address: ___________________

____

Emergency Contact

Name: ___________________________

Relationship: _______________________

Home Phone: _______________________

Cell Phone: ________________________

Work Phone: _______________________

Guarantor (Who is Responsible for This Account) Patient Other

Name: ___________________________

Relationship to Patient: ______________

Street Address: ______________________ City: ____________ State: _____ Zip: ________

DOB: ___/___/______ SSN# ____-_____-______

Primary Insurance Information

Insurance Co. Name: __________________

Policy ID #: _______________________

Phone #: __________________________

Group #: __________________________

Street Address: ______________________ City: ____________ State: _____ Zip: ________

Secondary Insurance Information

Insurance Co. Name: __________________

Policy ID #: _______________________

Phone #: __________________________

Group #: __________________________

Street Address: ______________________ City: ____________ State: _____ Zip: ________

Insurance Authorization and Assignment

I hereby authorize Spencer Rozin, M.D. and/or Rozin Internal Medicine to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. I acknowledge this authorization for assignment of benefits will continue indefinitely unless revoked in writing by me. I will be responsible for all collection fees incurred if an outside collection agency is used to recover past due balances. I have read, understand and agree to the Payment Policies of Rozin Internal Medicine.

______________________________ ______________ ______________

Signature Relationship Date

Rozin Internal Medicine
Spencer I. Rozin, MD FACP
721 Wellness Way, Suite 220
Lawrenceville, GA 30046

Office (770) 709-0900 **Fax (770) 709-7444**

PAYMENT POLICIES effective January 1, 2015

If the Patient is not covered by any health insurance plan or Rozin Internal Medicine (the "Practice") is not a participating provider with the Patient's health plan, full payment of all office visits and other service(s) charges is expected at the time services are provided. If the Patient has insurance with which the Practice does not participate, the Practice will not file claims to these carriers. Under such circumstances, the Patient will be responsible for an office visit charge based on the services provided. A $40.00 charge may be billed to any patient who does not pay these charges at the time of service. If the Patient is hospitalized and the Practice is actively engaged the Patient's care, the Patient will be responsible for a daily hospital visit charge of $150*. The Patient agrees to be personally financially responsible for all such charges.

Charges for all covered medical services, not including services provided as part of the Amenities included in the Practice-Patient Agreement, are the responsibility of the Patient. The Practice will file insurance claims only for patients with Medicare coverage or if the Practice is "in network" with the Patient's plan, and if the Practice has a current copy of the Patient's insurance card on file. However, ultimately, the Patient is responsible for the payment of all charges. It is the policy of the Practice to collect all fees, co-payments, co-insurance, non-covered services charges and deductibles as required by the Patient's insurance provider at the time of service. A $40.00 charge may be billed to any patient who does not pay these charges at the time of service, and the Patient agrees to be personally financially responsible for all such charges. Certain tests or procedures the Practice performs are considered screening, not medically necessary, or experimental by some insurance companies and Medicare. The Practice may not know at the time of the Patient's visit if the Patient's insurance company will pay for all services provided, and the Patient may not be notified that a service is not covered at the time of the visit. If the Patient's insurance provider does not pay for these services, excluding those services included as Amenities in the Practice-Patient Agreement, the Patient accepts responsibility for full payment of any such charges. Charges for certain screening procedures must be paid for by the Patient prior to having the service provided.

The State of Georgia mandates that insurance providers pay for undisputed claims within 30 days of submission. If the Practice is an "in network" provider with the Patient's insurance provider, the Practice allows 35 days for the Patient's insurance providers to pay a claim. If the Patient's insurance provider has not paid in full by that time, the Patient will be responsible for all outstanding charges. The Patient is requested to follow-up with his or her insurance provider to make sure that all claims are paid promptly. The Practice will refund any overpaid amount to the Patient or insurance provider as appropriate. The Practice relies upon the insurance information provided by the Patient in order to submit insurance claims on behalf of the Patient. Many insurance provider plans require the Practice to obtain pre-approval for certain procedures before they will pay for them. If the Practice does not have accurate information about the Patient's insurance coverage, the Practice cannot obtain pre-approval for a service and the Patient may then be responsible for all charges not pre-approved. Also, many insurance plans have a "Timely Filing Requirement" which limits how long after a service is performed that the Practice can file a claim. If the Practice does not have correct insurance information, the Practice may not be able to file the Patient's claim before the "timely filing" period ends. If the insurance information provided by the Patient is not accurate, the Patient will be liable for the full amount of all charges and agrees to pay these charges in full.

Patients who fail to attend a confirmed appointment, or who cancel with less than 24 hours notice, may be billed and agree to be responsible for full payment of a $50.00 charge. If the Patient does not attend an appointment for a treadmill stress test, the Patient will be charged and agrees to be responsible for full payment of a $100.00 charge.

If the Patient does not show up for a Fitness Assessment appointment with the Practice or its partner(s), the Patient will be billed and agrees to be responsible for full payment of a $75.00 charge.

Account Credits – If the Patient, his or her spouse, or a Patient's dependent has a credit on their account, the Patient authorizes the Practice to use that credit at any time toward payment of any amounts owed on either account.

Delinquent Accounts – Once the Practice has exhausted its internal efforts to obtain payment for service, the Practice will refer accounts to an outside collection agency. These agencies report delinquent accounts to credit reporting services. The Patient will be charged and agrees to pay a $50.00 fee, as well as all collection and/or attorneys fees that the Practice incurs trying to collect on the Patient's account. If the Practice is required to commence legal proceedings for non-payment, the Patient agrees to pay for all court costs and attorney fees associated with recovery of any delinquent accounts.

Returned checks – Occasionally, a check written to the Practice is returned unpaid. When this happens, the Practice will contact the Patient. Returned checks must be paid in full within 10 days of notification, plus a $40.00 fee. The Practice will, if necessary, commence legal proceedings to collect on returned checks and the Patient will be responsible for all fees associated with these collection efforts.

Medical/Personal Health Information ("PHI") records fee – The Patient understands that federal and state laws allow for a fee to be charged for copying of patient records and the Patient will be personally responsible for the payment of such fees. One copy of up to 75 pages of patient records will be provided at no cost. Any records over 75 pages, and any records after the first copy, will be billed at the current rates payable prior to records being released. If the Patient requests that his or her PHI be provided on a paper copy or portable media (such as compact disc or universal serial bus (USB) flash drive), the Patient acknowledges that the Practice's actual supply costs for such equipment may be charged to the Patient.

Annual fee payment for Practice Amenities is due on enrollment and may be made by credit card or check made payable to Rozin Internal Medicine. Semiannual payments are by credit card only, 60% upon enrollment and 40% due six (6) months after Effective Date. **Payment plans do not apply to patients that join after January during any enrollment year.** The Patient must pre-authorize a credit card charge for the second payment at time of enrollment in the Program. If paying by credit card, 3% of the charged amount will be added per credit card transaction. Patients joining after January must pay the annual fee in full upon joining the Practice. The Patient understands that, should the Patient leave the Practice at any point during the year, either voluntarily or by dismissal of the Practice, the Patient is financially responsible for a $150.00 processing fee. This fee will either be deducted from any refund due to the Patient or the Patient hereby gives permission to the Practice to process this fee with the credit card on file. The Practice will provide only non-routine care for 30 days after termination of the Patient's participation in the program. After this time, the Practice will no longer be responsible for any aspect of the Patient's medical care and the Patient should establish with/ see his or her new physician for all medical issues. The Patient and/or his or her insurance provider as the case may be, will be responsible for any applicable Practice charges incurred for care provided during this time.The Patient acknowledges that he or she has read, understands and agrees to comply with the Practice's Payment Policies. This consent will remain in effect unless revoked in writing.

____________________________ ____________________________

Signature Print Name

Date____________________________

*subject to change

Rozin Internal Medicine
Spencer I. Rozin, MD FACP
721 Wellness Way, Suite 220
Lawrenceville, GA 30046
Office (770) 709-0900 **Fax (770) 709-7444**

Electronic Communications Agreement for Protected Health Information ("PHI")

Rozin Internal Medicine ("Practice") and ______________________________("Patient") herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of texting, email or other electronic communications/transmissions. The Patient authorizes the Practice to use standard email to communicate with the Patient regarding his or her PHI. Under no circumstances shall the Patient use email or electronic communications in urgent or emergency situations. The Patient understands and acknowledges that he or she must contact the Practice directly by phone for all time sensitive issues, including urgent or emergent situations. The practice encourages the Patient to use email to ask non-time sensitive questions. The Patient acknowledges that he or she is responsible for making a follow up telephone call to the Practice if the Patient does not receive a response to an email within 72 hours. The Patient recognizes that email communications may become part of the permanent medical record.

The Patient authorizes the Practice to disclose the Patient's email address and other ePHI to Living Fit Studios, Inc., for the purpose of scheduling the Patient's wellness assessment as part of his or her comprehensive consultation. By providing consent to disclose his or her email address and other ePHI, the Patient understands that he or she is not obligated to receive the wellness assessment, but is providing permission to be contacted electronically for scheduling purposes.

This consent will remain in effect unless revoked in writing by the Patient. The Patient may revoke this consent in writing at any time by doing the following: writing, signing, and dating a letter to the Practice's Privacy Officer. This letter must include the Patient's name, address, social security number, e-mail address and birth date, and must state that the Patient wishes to revoke consent to authorize the use of email communication. The Patient understands that PHI released prior to canceling consent is not covered by this cancellation.

The Patient further acknowledges that any failure to comply with the terms of this Agreement may result in the Practice terminating the email and electronic communications relationship, and may lead to the termination of participation with the Practice's Program and the Practice-Patient Agreement.

The Patient agrees that it is the Patient's responsibility to inform the Practice of any changes to the authorized email address, or if at any time the Patient chooses to cease using email as a means of communicating with the practice. The Patient understands that should the Patient send an email communication via another email address, the Practice will be authorized to use that email address for communicating PHI as well.

The Patient acknowledges that he or she has been informed of, and understands, the risks and procedures involved in using email communication of PHI. The Patient agrees to the terms listed on this form and consents to and authorizes the use of texting and email as one form of communication with the Practice.

For all other services, the Patient understands that the Practice may use telephone (landline or mobile), facsimile, mail, or in-person office visits. The Patient concurrently agrees to the terms of the Practice-Patient Agreement.

The Practice values and appreciates your privacy and takes security measures such as encrypting your data, password-protected data files, and other authentication techniques to protect the your privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this Agreement reflecting your explicit consent to certain communication amenities.

The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, my information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this Agreement. The Patient shall hold harmless the Practice and its owners, officers, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or caused by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.

The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the your identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practices, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with me and all people described above.

The Patient hereby consents to the Practice engaging in electronic and after-hours communications referenced above regarding his or her PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties as follows:

Furthermore, the Patient authorizes and consents to the Practice discussing private healthcare information and/or treatment plan with the following people:

Spouse:____

Mother/Father:____

Children:____

Siblings:____

Other (please specify):____

The Patient understands that, in order to facilitate the provision of health care, the Practice will need to contact the Patient from time to time, for a variety of reasons, including: appointment reminders, report test results, advice of any special precautions and/or instructions to follow

before and/or after a procedure, and in reference to any medication use. The Patient authorizes the Practice to contact him or her in the following ways:

<u>*Please check all options that apply and ensure that the Practice has current information.</u>

__X__ by mail ____by home phone ____by cell phone ____by work phone

____Yes ____No May we leave a detailed message on your answering machine/voicemail at the home/work/cell phone?

The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient above as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of your PHI and HIPAA/HITECH compliance. The Patient acknowledges receipt of the Practice's Notice Of Privacy Practices and acknowledges receipt of same.

The Patient understands that he or she has the right to request from the Practice a copy of his or her PHI and an explanation or summary of that PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information. However, the Practice's Annual Fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If I request that my PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive), the Patient acknowledges that the Practice's actual supply costs for such equipment may be charged directly to the Patient.

The Patient agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove him or her from any PHI electronic communications database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment. The Patient understands that revocation of this Agreement will preclude the Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. The Patient further acknowledges that such request to remove Patient from the Practice's PHI electronic communications database or network applies only to future communications and any prior electronic communications is excluded from such request.

____

Patient Email Address for Communicating PHI

____

Print Patient Name

______________________________________ ____________

Patient or legally authorized individual signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

The Practice is required to provide you with a copy of our Notice of Privacy Practices, which states how the Practice may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

Patient's name (please print): ______________________________

Signature: ______________________________ **Date:** ______________

Responsible party's name (if different from patient) (please print): ______________________________

Signature: ______________________________ **Date:** ______________

FOR OFFICE USE ONLY

The Practice made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from Patient but it could not be obtained because:

☐ **The Patient refused to sign.**

☐ **Due to an emergency situation it was not possible to obtain an acknowledgment.**

☐ **The Practice was unable to communicate with the Patient.**

☐ **Other:** ______________________________

____

____

____

Rozin Internal Medicine
Spencer I. Rozin, MD FACP
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NOTICE OF PRIVACY PRACTICES

FEDERAL LAW REQUIRES THE PRACTICE TO MAKE THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") AVAILABLE TO ALL PERSONS AND TO MAKE A GOOD FAITH EFFORT TO OBTAIN A SIGNED DOCUMENT ACKNOWLEDGING PATIENTS' RECEIPT OF THIS NOTICE. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR PERSONAL HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR PERSONAL HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

When Is The Notice Effective?
This Notice became effective on January 1, 2015. We reserve the right to change this Notice after the effective date. We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record,
- Correct your paper or electronic medical record,
- Request confidential communication,
- Ask us to limit the information we share,
- Get a list of those with whom we have shared your information,
- Get a copy of this Notice,
- Choose someone to act for you, and
- File a complaint if you believe your privacy rights have been violated.

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition,
- Provide disaster relief,
- Include you in a hospital directory,
- Provide mental health care,
- Market our services and sell your information, and
- Raise funds.

Our Uses and Disclosures
We may use and share your information as we:

- Treat you,
- Run our organization,
- Bill for your services,
- Help with public health and safety issues,
- Do research,
- Comply with the law,
- Respond to organ and tissue donation requests,
- Work with a medical examiner or funeral director,
- Address workers' compensation, law enforcement, and other government requests, and
- Respond to lawsuits and legal actions.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care,
- Share information in a disaster relief situation, and
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease,
- Helping with product recalls,
- Reporting adverse reactions to medications,
- Reporting suspected abuse, neglect, or domestic violence, and
- Preventing or reducing a serious threat to anyone's health or safety.

Do research
We can use or share your information for health research

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims,
- For law enforcement purposes or with a law enforcement official,
- With health oversight agencies for activities authorized by law, and
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Patient Personal Health Questionnaire
ROZIN Internal Medicine
Spencer I. Rozin, MD FACP

Name: ______________________ Sex: M / F Age: _______ Birthplace: ____________

Martial Status S / M / D / W Referred By: ______________________

Employed By: ______________________ Highest Level of Education: HS College Post Grad

Why are you here today (Please list area of major concern if any):

____

____

____

Personal Medical History (MARK ALL THAT APPLY)

- ○ Heart Disease/Heart Attack
- ○ High Blood Pressure
- ○ Diabetes
- ○ High Cholesterol/Triglycerides
- ○ Stroke
- ○ Cancer
- ○ Thyroid Disease
- ○ Heart Murmur
- ○ Mitral Valve Prolapse
- ○ Heart Failure
- ○ Atrial Fibrillation
- ○ Irregular Heart Beat
- ○ Osteoporosis
- ○ Arthritis
- ○ Migraines/Headaches
- ○ Colon Polyps
- ○ Other: ______________________
- ○ Depression/Anxiety
- ○ Kidney Problems/Stones
- ○ Liver Problems
- ○ Lung Disease/Asthma
- ○ Stomach Ulcers
- ○ Irritable Bowel Syndrome
- ○ Diverticulosis
- ○ Sleep Apnea
- ○ Anemia/B12 Deficiency
- ○ Blood Clots
- ○ Gout
- ○ Fibromyalgia
- ○ Glaucoma
- ○ Meningitis
- ○ Sexually Transmitted Disease
- ○ Neurological Problems
- ○ Other: ______________________

Surgery (Check all that apply and year of surgery)

- ○ Tonsillectomy ______
- ○ Appendectomy ______
- ○ Gallbladder ______
- ○ Hernia ______
- ○ Hemorrhoids ______
- ○ Vasectomy ______
- ○ Cataracts ______
- ○ Tubal Ligation ______
- ○ C-Section #______
- ○ D & C #______
- ○ Sinus Surgery ______
- ○ Plastic Surgery ______
- ○ Thyroid ______
- ○ LASIK ______

Name: ______________________

Date: _____/_____/_____

Surgery (continued)

○ Breast Biopsy Left Right

○ Knee Surgery Left Right

○ Hip Surgery Left Right

○ Back Surgery #______ Level

○ Cancer Surgery ____________________

○ Hysterectomy ___Abdominal ___Vaginal

Reason________________________________

○ Ovaries ___Present ___Removed

○ Ear Tubes/Surgery

○ Other ________________________________

Childhood Illnesses

○ Mumps

○ Measles

○ Chicken Pox

○ Rheumatic Fever

○ Scarlet Fever

○ Other ____________________

Vaccines & Year Received

○ Tetanus ______

○ Influenza ______

○ Pneumonia ______

○ Hepatitis A ______

○ Hepatitis B ______

○ Shingles ______

○ Other ____________________

Smoking History

○ Never

○ Quit Year ______

○ Years Smoked ______

○ Want to Quit

○ Cigarettes

Amount per day_____ wk_____

Years _____

○ Cigar _____/day _____wk

○ Pipe _____/day _____wk

Alcohol History

○ Never

○ Quit Year ______

○ Want to Quit

○ Amount

Beer _____/day _____/wk _____/mo

Wine _____/day _____/wk _____/mo

Liquor _____/day _____/wk _____/mo

Family History

☐ Adopted or Unknown

Mother Age _____ Deceased (cause) ______________________

Medical Problems:

Father Age _____ Deceased (cause) ______________________

Medical Problems:

Brothers/Sisters

First Name			Medical Problems
________________	M / F	Deceased	________________
________________	M / F	Deceased	________________
________________	M / F	Deceased	________________
________________	M / F	Deceased	________________

Children

________________	M / F	Deceased	________________
________________	M / F	Deceased	________________
________________	M / F	Deceased	________________
________________	M / F	Deceased	________________

Other relatives not already listed (if known). Please list relationship

- ○ Heart Disease/Heart Attack ________
- ○ Heart Failure ________
- ○ High Blood Pressure ________
- ○ Diabetes ________
- ○ High Cholesterol/Triglycerides ________
- ○ Stroke ________
- ○ Thyroid Problems ________
- ○ Osteoporosis ________
- ○ Migraines/Headaches ________
- ○ Colon Polyps/Cancer ________
- ○ Other: ________________________
- ○ Depression/Anxiety ________
- ○ Kidney Problems/Stones ________
- ○ Liver Problems ________
- ○ Lung Disease/Asthma ________
- ○ Blood Clots ________
- ○ Neurological/Tremors ________
- ○ Alzheimer's ________
- ○ Accidental/Suicide ________
- ○ Lupus or similar ________
- ○ Cancer and Type ________________________
- ○ Other: ________________________

Exercise

Type

Frequency

Any Problems

Seat belt use

☐Always ☐over 75% ☐50-75% ☐less than 50%

Health Screening

Mammogram Year_____ Results

PAP Smear Year_____ Results

Bone Density Year_____ Results

Prostate Exam Year_____ Results

Colonscopy/Sigmoidoscopy Year_____ Results

Cardiac Stress Test

Treadmill Year_____ Results

Nuclear/Chemical Year_____ Results

Eye Exam Year_____ Results

Chest Xray Year_____ Results

TB Skin Test Year_____ Results

Other (CT's/Aorta Ultrasound) Year _____ Results

Name: ________________________

Date: _____/_____/_____

Medications (Prescriptions/Vitamins/Supplements)

Medications		
Name	Dose	Frequency

Allergies	
Name	Reactions

Review of Symptoms (Please check if you have or have had ongoing problems with the following.)

General

- ○ Fatigue
- ○ Sleep Problems
- ○ Night Sweats
- ○ Weight Gain/Loss Amount_______ Over what period of time______
- ○ Fevers
- ○ Appetite Changes
- ○ Excessive Thirst

Skin

- ○ New or changing moles/lesions
- ○ Recurrent Rash
- ○ Rosacea

Neck

- ○ Pain
- ○ Swelling

Eyes

- ○ Double Vision
- ○ Blurry Vision
- ○ Changing Vision
- ○ Pain
- ○ Dry/Gritty Eyes
- ○ Other ______________________________

Ears/Nose/Throat/Sinus

- ○ Ringing in Ears
- ○ Decreased Hearing
- ○ Ear Pain
- ○ Recurrent Cold Sores/Mouth Ulcers
- ○ Persistent Hoarseness
- ○ Recurrent Sinus Infections
- ○ Sinus Draingage

Lungs/Breathing

- ○ Recurrent Cough
- ○ Sputum Production
- ○ Shortness of Breath
    - ○ At Rest
    - ○ With Exertion
    - ○ Wakes me at night
- ○ Wheezing
- ○ Stop Breathing During Sleep
- ○ Snoring
- ○ Coughing up Blood

Heart

- ○ Chest Pain/Pressure/Fullness
- ○ Chest Tightness/Squeezing/Heaviness
- ○ Palpatations
- ○ Skipped Beats/Fluttering
- ○ Pass Out Spells
- ○ Leg Swelling
- ○ Leg/Buttock Pain or Cramps with Exertion
- ○ Must Sleep Propped Up

Stomach/Bowels

- ○ Difficulty with/Painful Swallowing
- ○ Heart Burn
- ○ Acid Reflux
- ○ Indigestion
- ○ Recurrent Nausea/Vomiting
- ○ Abdominal Pain
- ○ Bloating/Gassy
- ○ Constipation
  - ○ BM Frequency ______
- ○ Diarrhea
  - ○ BM Frequency ______
- ○ Change in Bowel Frequency
- ○ Change in Bowel Character
  - ○ Size
  - ○ Shape
  - ○ Consistency
- ○ Blood In/On Stool
- ○ Blood on Toilet Tissue
- ○ Hepatitis/Jaundice
- ○ Pancreatitis
- ○ Lactose Intolerance
- ○ Food Intolerance(s)

Urinary

- ○ Pain/Burning with Urination
- ○ Loss of Urine with Coughing, Sneezing Laughing, Straining
- ○ Loss of Urine if can't get to the Bathroom Quickly
- ○ Blood in Urine

Women

- ○ Breast Pain/Nipple Discharge
- ○ Abnormal Menstrual Cycles
- ○ Vaginal Discharge
- ○ Painful Intercourse
- ○ Miscarriage #______
- ○ Abortions #______
- ○ Last Menstrual Cycle Date______

Men

- ○ Difficulty Getting Erections
- ○ Difficulty Maintaining Erections
- ○ Nighttime Urination #_____
- ○ Loss of Libido
- ○ Prostate Infections

Hematology

- ○ Easy Bruising/Bleeding
- ○ Transfusions

Neurological

- ○ Numbness/Tingling
- ○ Dizziness
- ○ Tremor
- ○ Seizures
- ○ Memory Problems
- ○ Muscle Weakness

Psychiatric

- ○ Depressed/Sad/Blue
- ○ Anxious/Nervous
- ○ Crying Spells
- ○ Poor Concentration
- ○ Decreased Motivation
- ○ Decreased Enjoyment of Activities
- ○ Suicidal Thoughts/Acts

Muscular

- ○ Muscle Pain
- ○ Joint Pain
- ○ Joint Swelling
- ○ Limitation of Joint Motion

Name: ____________________________

Date: ______/______/______

For Physician Use