PARK MEDICAL ASSOCIATES, LLC **PARK MEDICAL LABORATORY**
10755 FALLS RD. SUITE 200 LUTHERVILLE, MD 21093

PATIENT REGISTRATION: Fill in online and print, or print and fill out using black ink. Use the [TAB] key or Right Arrow key to move to the next field. To move backward, use the Left Arrow key. Pressing F1 in select fields will provide helpful hints on how to enter the data.

Primary Physician:

☐BELITSOS ☐BYRD ☐HADLEY ☐MAGAZINER ☐MOLAVI ☐MOLINARO ☐NEWMAN ☐POZEFSKY
☐PRESSMAN ☐SAVADEL ☐SEIFTER ☐SHISHODIA ☐SIMONSON ☐STEINER ☐WILKENFELD

PLEASE PRINT **Today's Date**: **Appt. Date**: **Appt. Time**:

PATIENT INFORMATION

LAST NAME	FIRST	MI	Social Security #	JHH HIST#

ADDRESS	REFERRING DOCTOR

CITY	STATE	ZIP or Postal Code	COUNTRY	SEX ☐M ☐F	DATE of BIRTH	MARITAL STATUS ☐M ☐S ☐W ☐D ☐Other

PREFERRED LANGUAGE: ☐ English ☐ Other (please specify) ☐ Decline to answer

RACE: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Decline to answer

ETHNICITY: Are you of Hispanic Origin? ☐ YES ☐ NO ☐ Decline to answer

HOME PHONE	CELL PHONE	WORK PHONE EXT	SPOUSE'S NAME

eMAIL ADDRESS	OCCUPATION	SPOUSE'S OCCUPATION	SPOUSE'S DATE OF BIRTH

NAME OF EMPLOYER	SPOUSE'S EMPLOYER

EMPLOYER ADDRESS	SPOUSE'S EMPLOYER'S ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

☐ EMPLOYED STUDENT: ☐ FULL-TIME ☐ PART-TIME

SPOUSE'S WORK PHONE EXT	SPOUSE'S' CELL PHONE

PERSON TO NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP	PHARMACY NAME

WORK PHONE	EXT	PHARMACY ADDRESS

HOME PHONE	CELL PHONE	PHARMACY PHONE

INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE	NAME OF SECONDARY INSURANCE

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

PHONE	EFFECTIVE	PHONE	EFFECTIVE

POLICY #	GROUP #	POLICY #	GROUP #

IS POLICY HOLDER THE PATIENT? YES ☐ NO ☐ IS POLICY HOLDER THE PATIENT? YES ☐ NO ☐

POLICY HOLDER LAST NAME	FIRST	MI	POLICY HOLDER LAST NAME	FIRST	MI

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

SOCIAL SECURITY #	SEX	DATE OF BIRTH	SOCIAL SECURITY #	SEX	DATE OFBIRTH

RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER	RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER

EMPLOYER OF POLICY HOLDER if not listed above	EMPLOYER OF POLICY HOLDER if not listed above

PAYMENT OF BENEFITS

I authorize Park Medical Associates and Park Medical Laboratory to file insurance on my behalf and release any medical or other information necessary to process my claims. When applicable, I authorize payment of benefits directly to the physician or laboratory. I understand that Park Medical Laboratory and the physicians of Park Medical Associates (excluding John Aucott, M.D.) participate in all Cigna (except Worker's Comp) and CareFirst networks. I understand that the physicians and the lab also participate with EHP. I understand that the Park Medical physicians do ***not*** accept Medicare assignment (except for Dr. Seifter). I understand that the physicians and the lab do ***not*** participate with any other commercial insurance or HMO. Park Medical Laboratory participates with Medicare. Specialized testing services sent to an outside reference lab will be billed separately by that testing facility. I understand that I am responsible and agree to pay for any balance not covered by my insurance.

Signature _____ Date _____

Park Medical Associates/Park Medical Laboratory (Revised November 13, 2013)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact
our Privacy Officer Sally Finkel at 10755 Falls Rd., Suite 200, Lutherville, MD 21093; Telephone: 410-583-7101

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. Also, we may request and use your prescription medication history from other healthcare providers or 3rd-party pharmacy benefit payors for treatment purposes.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: If authorized by law we may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties. If authorized by law we may also disclose protected health information to a funeral director, in order to permit the funeral director to carry out their duties. If authorized by law we may disclose such information in reasonable anticipation of death. If authorized by law protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Marketing and Fundraising: Park Medical does not use patient information in any way for marketing purposes. Park Medical does not solicit patients for fundraising purposes. Park Medical will not sell Patient information.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you.
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. You have the right to request an electronic copy of your protected health information. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **Sending written notice as described above to: Sally Finkel at 10755 Falls Rd. Suite 200, Lutherville, MD 21093**

Restricting information release. You have the right to request that we do not disclose information about a specific service to an insurance plan only if the service is paid out of pocket and in full at the time of service. The request must be in writing naming the specific service, date and insurance plan to which the information is not to be disclosed.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

E-mail communication. If you choose to communicate through e-mail, we may respond to you in the same manner in which the communication was received and to the same email address from which you sent your email. Before using email to communicate with us, you should understand that there are certain risks associated with the use of email, such as misdirected/misaddressed messages, email accounts that are shared by others, messages that can be forwarded on to others, or messages stored on portable electronic devices that have no security. Additionally, you should understand that the use of email should not take the place of professional medical advice, diagnosis or treatment. Email communication should never be used in a medical emergency.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Breach Notification. Park Medical will notify you in writing if there has been a breach affecting your protected health information. A breach is when your protected health information may have been disclosed or used in a way that is inconsistent with the law and results in being compromised.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Park Medical reserves the right to revise our Notice of Privacy Policy. Patients will be offered a revised policy as appropriate. You may view/print the policy from our website: www.parkmedical.net

We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services (800) 368-1019 and/or The Office of Civil Rights (866) 627-7748 if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Sally Finkel** at (410)583-7101 for further information about the complaint process.

This notice was published and becomes effective on **November 13, 2013.**

PARK MEDICAL ASSOCIATES LLC FINANCIAL POLICY (FP++) Eff. 6/1/18

We would like to thank you for choosing Park Medical Associates as your medical provider. We pride ourselves on providing all patients with excellent patient service. Billing costs have risen enormously and we ask your help in controlling these costs. To keep you informed of our current financial policies, please read the following, and sign at the bottom. We ask that you keep a copy of this document for future reference.

Insurance

The physicians of Park Medical Associates participate with EHP, Cigna and CareFirst BlueCross BlueShield. They are authorized to provide services to Medicare patients, but they do not accept Medicare assignment (except for Dr. Seifter). Park Medical Laboratory participates with Medicare, EHP, Cigna & BCBS for lab tests. It is the patient's responsibility to provide our office with a copy of your current insurance card, and to inform us of any changes in insurance. Although we file claims for most insurance plans on your behalf, you are ultimately responsible for payment of the bill.

Copays, Co-insurance, Deductibles, and Non-covered Services

Copays are payable at the time of service. We accept cash, check (no foreign checks), or credit card (VISA, MasterCard, Discover and American Express). Co-pays, co-insurance and deductibles cannot be waived by our practice, as they are requirements placed on you by your insurance carrier. You are responsible for any non-covered services as determined by your insurance plan (including forms). If you have an insurance plan with whom we do not participate, you are responsible for our bill in full.

Past Due Balances

You will be asked to pay any past due balances when making appointments or before seeing the physician. If your balance is especially high, you can set up a payment plan with a Patient Service Coordinator or Billing Coordinator.

Returned Checks

A $25 charge will be added to your account for any check returned by your bank.

Finance Charge/No Show Fee/Cancellation Fee

If your bill is over 90 days old, we will impose a finance charge of $15. This fee will help to offset the excessive monthly costs involved in continuing to send overdue bills. If you are on a payment plan, and meet your monthly payment obligation, a finance charge will not be assessed. We reserve the right to charge a fee of $75 for no show appointments and a $50 cancellation fee for appointments cancelled within 24 hours at the doctor's discretion.

Collections Fee

If after 2-3 months a balance remains unpaid, we will send the account to our collections attorneys. We will impose a collections fee of one third of the outstanding bill to cover the fee charged to us by the collection agency.

_____

Signature Date

_____

Print Name

Name_____ DOB _____ Date _____

Park Medical Associates
New Patient History

(Please Print Clearly)

Patient Name: _____ **Date of Birth**:____/____/_____

Sex: Male____ Female____

Reason for Visit: (Please list your major medical concerns)

_____

_____

Allergies	**Reaction**

MEDICATIONS Please list all medications you are taking including prescription, over the counter, vitamins and herbal

(Please list each Medication and dosage)

Medication Name	Dosage	How Many Times a Day?	Refill Needed? Yes / No

Preferred Pharmacy _____ _____

Name **Location/Address or Phone Number**

Patient Initials_____

Name_____ DOB _____ Date_____

PAST MEDICAL HISTORY

Medical History – Please check any of the following that you have been diagnosed with.

□ Anorexia/Bulimia
□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blocked Arteries
□ Blood Clots
□ Bronchitis
□ Cancer Type:_____
□ Hemorrhoids
□ Cataracts
□ Chronic Constipation
□ Colon Polyps
□ COPD/Emphysema
□ Degenerative Disc Disease
□ Depression
□ Diabetes/Pre-Diabetes
□ Diverticulitis
□ Fibroids
□ Frequent Urinary Infections
□ Gallstones
□ GERD
□ Glaucoma
□ Gout
□ Headaches
□ Heart Attack
□ Heart Failure
□ Heart Murmur
□ Hemorrhoids
□ Hepatitis
□ Herniated Disc
□ High Blood Pressure
□ High Cholesterol/Triglycerides
□ HIV
□ Hyper or Hypothyroidism
□ Inflammatory Bowel Disease
□ Insomnia
□ History of Blood Transfusion
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Kidney Stones
□ Meningitis
□ Macular Degeneration
□ Obesity
□ Osteopenia
□ Osteoporosis
□ Peripheral Vascular Disease/Poor Circulation
□ Pneumonia
□ Pre-eclampsia
□ Prostate Problems
□ Rheumatic Fever
□ Seasonal Allergies
□ Seizures
□ Sleep Apnea
□ Stroke
□ Tuberculosis
□ Varicose Veins
□ Ulcers
□ Alcohol Abuse Quit Date:_____
□ Substance Abuse Quit Date:_____

Any Others:_____

Surgical / Procedure History – Please check any of the following you have had, and list the month/year performed.

□ Appendectomy _____
□ Bunionectomy _____
□ Carotid Surgery _____
□ D&C _____
□ Lumpectomy _____
□ Lasik Surgery _____
□ Tonsillectomy _____
□ Tubal Ligation _____
□ Uterus Removal _____
□ C-Section _____
□ Cataract Removal _____
□ Hemorrhoidectomy _____
□ Hip Surgery _____
□ Kidney Stones _____
□ Hip Replacement _____
□ Prostate Removed _____
□ Ovaries Removed _____
□ Joint Surgery _____
□ Cardiac Bypass _____
□ Gallbladder Removal _____
□ Hernia Repair _____
□ Cardiac Stents _____
□ Thyroidectomy _____
□ Knee Replacement _____
□ Vasectomy _____
□ Back Surgery _____

Any Others:_____

Hospitalizations – Please list any other hospitalizations you may have had.

1. Reason: _____
   Date: _____
   Hospital: _____

2. Reason: _____
   Date: _____
   Hospital: _____

3. Reason: _____
   Date: _____
   Hospital: _____

4. Reason: _____
   Date: _____
   Hospital: _____

Women's Health

Number of Vaginal Deliveries:_____
Number of Miscarriages:_____
Number of Abortions:_____
Age of First Period:_____

Number of Pregnancies:_____
Number of C-Sections:_____
Abnormal PAP's?_____
Age of Menopause (if applicable)? _____

Patient Initials_____

Name_____ DOB _____ Date _____

SOCIAL HISTORY

Personal History

Marital Status □ Single □ Significant Other □ Married □ Divorced □ Widowed

Children: □ Yes □ No Number of children _____ Ages of children_____

Living Situation: □ Live Alone □ With Significant Other/Spouse □ With Children/Family Members □ Other

Occupation: _____

Highest level of education: _____

Hobbies/Interests: _____

Tobacco

Have you ever smoked? □ Yes □ No If yes, what do you (did you) smoke? _____

Are you still smoking? □ Yes □ No

If no: How many years ago did You quit? _____ For how many years did you smoke? _____ How many packs/day did you smoke? _____

If yes: How many years have you smoked? _____ How many packs/day do you smoke? _____

Have you ever tried to quit? _____

Alcohol

Do you drink alcohol including beer, wine, or other alcohol? □ Yes □ No

If yes please specify frequency

□ Daily □ Almost Daily (4-6 times/week) □ 1-3 times per/week □ Less than one time/week

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? □ Yes □ No

(including marijuana, cocaine, amphetamines, pain or anxiety medications, etc)

If yes please specify type of drug and frequency of use -_____

Diet/Activity

Are you on any special diet? □ Yes □ No

If yes, how would you describe your diet? (e.g. South Beach, Atkins, calorie intake, renal, diabetic, low sodium, low fat, etc.)

_____

Do you drink caffeine? □ Yes □ No If yes, how many cups per day? _____

Do you currently participate in any regular activity to improve or maintain your physical fitness (either on your own or in a formal class)? □ Yes □ No If yes, please describe:

How many hours of sleep do you get per night, on average? _____

Sexual History

Are you sexually active? □ Yes □ No □ Never Do you use condoms? □ Yes □ No

Sexual Partners: □ Male □ Female □ Both

Do you have a history of STDs? □ Yes □ No If yes, what type(s)?_____

The CDC recommends that everyone be screened for HIV.

Do we have your permission to test you for HIV? □ Yes □ No

Are you currently, or have you ever been a victim of domestic violence? □ Yes □ No

Patient Initials_____

Name_____ DOB _____ Date_____

FAMILY HISTORY

	Deceased?	Aneurysm	Arthritis	High Blood Pressure	Heart Problems	High Cholesterol	Lung Problems	Autoimmune Disease	Stroke	Seizures/Epilepsy	Breast Cancer	Skin Cancer	Ovarian Cancer	Colon Cancer	Prostate Cancer	Diabetes	Kidney Disease	Thyroid Problems	Osteoporosis	Bleeding Problem	Allergies/Asthma	Depression/Anxiety	Gastrointestinal Disease	Others (Please List)
Father																								
Mother																								
Paternal Grandfather																								
Paternal Grandmother																								
Maternal Grandfather																								
Maternal Grandmother																								
Brother																								
Brother																								
Sister																								
Sister																								
Son/Daughter																								
Son/Daughter																								
Other																								
Other																								

Check the appropriate item listed across the top row for each relative. Please list only blood relatives.

Patient Initials_____

Name_____ DOB _____ Date_____

Please check any of the following symptoms that you are currently experiencing or have experienced in the last 6 months.

GENERAL
□ Recent Fever
□ Excessive Fatigue
□ Unexplained Weight Loss/Gain
□ Night Sweats

EYES
□ Discharge
□ Pain or Burning
□ Blurred Vision
□ Loss of Sight
□ Itching or Watering

BREAST
□ Pain
□ Lumps
□ Nipple Discharge

RESPIRATORY
□ Cough
□ Coughing up Blood
□ Shortness of Breath
□ Wheezing
□ Snoring

REPRODUCTIVE-WOMEN
□ Irregular Periods
□ Spotting between periods
□ Vaginal discharge/burning/itching
□ Unusually painful periods
□ Pain/Trouble during intercourse

REPRODUCTIVE-MEN
□ Discharge from Penis
□ Pain or Swelling of Testicles
□ Pain/Trouble during intercourse
□ Problems with Erection

MENTAL HEALTH
□ Depression
□ Marital Problems
□ Trouble Sleeping
□ Panic Attacks
□ Anxiety
□ Thoughts of Harming Others
□ Thoughts of Suicide

SKIN
□ Change in Nails or Hair
□ Lumps
□ Recurrent Rashes
□ Sores that will not heal or bleed
□ Moles that are changing

EARS
□ Hearing Loss
□ Ringing
□ Earache
□ Feeling of Ear Fullness
□ Excessive Earwax

MOUTH & THROAT
□ Dry Mouth
□ Soreness or Bleeding in mouth area
□ Sore Throat
□ Mouth Ulcers
□ Hoarseness
□ Dental Issues

ENDOCRINE
□ Unusual intolerance of heat
□ Unusual intolerance of cold
□ Excessive Thirst
□ Excessive Hunger

URINARY
□ Pain/Burning with Urination
□ Frequent Urination
□ Blood in Urine
□ Trouble starting to Urinate
□ Waking up to Urinate
□ Leakage of Urine
□ Change in Stream

NERVOUS SYSTEM
□ Headaches
□ Seizures/Convulsions
□ Fainting Spells
□ Frequent Memory Loss
□ Weakness
□ Shakiness or Tremor
□ Loss of Sensation/Numbness
□ Feeling of Tingling in Limb
□ Speech Difficulty

NOSE & SINUSES
□ Bleeding
□ Nasal Congestion
□ Sneezing
□ Loss of Sense of Smell

NECK
□ Pain
□ Lumps

CARDIOVASCULAR
□ Abnormal/Irregular Heart Beat
□ Chest Pain
□ Awaken at night with breathing problems
□ Passing Out
□ Shortness of Breath
□ Swelling of Ankles
□ Leg Pain/Resting
□ Leg Pain/Walking

GASTROINTESTINAL
□ Unable to eat certain foods
□ Loss of Appetite/Weight
□ Food sticks in throat
□ Painful Swallowing
□ Heartburn
□ Indigestion
□ Vomiting
□ Nausea
□ Vomiting Blood
□ Abdominal or Stomach Pain
□ Diarrhea
□ Constipation
□ Recent Change in Bowel Habits
□ Blood in Stools
□ Black Stools

MUSCULOSKELETAL
□ Joint Pain
□ Joint Stiffness
□ Muscle Soreness

BLOOD DISORDERS
□ Easy Bruising
□ Excessive Bleeding

Patient Initials_____

Name_____ DOB _____ Date_____

PHYSICIANS YOU HAVE RECENTLY SEEN

Prior Primary Care Physician: Name: _____Location: _____

Specialists: Please list most recent physician and specialists you see or have seen;

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

HEALTH MAINTENANCE

If you have had any of the following performed, please check the box and list the month/year

□ Last Physical Exam _____
□ Last EKG _____
□ Last Eye Exam _____
□ Labs including a Cholesterol Screen _____

□ Mammogram (Females Only) _____
□ Pap Smear (Females Only) _____
□ Bone Density _____

□ Colonoscopy _____
□ Fecal Occult Blood Test (Blood in stool) _____

□ PSA (Males Only) _____

□ Shingles Vaccine (Zostavax) _____
□ Human Papilloma Virus Vaccine (HPV-Gardasil) _____
□ Vaccines Against Hepatitis _____
□ Influenza Vaccine _____

□ Tetanus Diphtheria (Td) _____
□ Tetanus Diphtheria Pertusis (Tdap) _____
□ Pneumonia Vaccine (Pneumovax) _____
□ TB Screening _____

HEALTH PLANNING

Do you have Advanced Directives in place? □ Yes □ No
□ Living Will □ Durable Power of Attorney □ Health Care Proxy □ Advanced Directives

We would like to thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every health care visit together.

Pre-visit instructions for laboratory tests:

- Fast after 12:00 midnight the night before the exam
- Patients may have water, black coffee, plain tea the morning of the exam
- Medications are to be taken as usual except for patients taking insulin
- Patients taking insulin should bring a light breakfast and their insulin. Inject insulin & eat breakfast after blood is drawn

Patient Initials_____