Health History Questionnaire

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Reason(s) for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ALLERGIES*:**  [ ] No known allergies

 Allergy Reaction

|  |  |
| --- | --- |
|  |  |
|  |  |

***MEDICATIONS*:**

Including prescriptions and over-the-counter drugs. [ ] No current medications

Drug Name Dosage/Frequency

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

***MY MEDICAL HISTORY*:** [ ] None Please circle all that apply.

Anxiety/Depression Gout Leg/Foot Ulcers

Arthritis Has Pacemaker Liver Disease

Asthma Heart Attack Osteoporosis

Bleeding Disorder Heart Murmur Overactive Thyroid

Blood Clots (or DVT) Hiatal Hernia or Reflux Disease Pulmonary Embolism

Cancer HIV/AIDS Reflux or ulcers

Coronary Artery Disease High Cholesterol Strokes

Diabetes High Blood Pressure Tuberculosis

Fibromyalgia Kidney Disease

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer Screening: M\_\_\_/D\_\_\_/Year\_\_\_\_ Cervical Cancer: M\_\_\_/D\_\_\_/Year\_\_\_\_\_

Influenza Vaccination: M\_\_\_\_/D\_\_\_\_\_/Year\_\_\_\_\_ Tetanus/T-DAP: M\_\_\_/D\_\_\_/Year\_\_\_\_\_\_\_\_ (past 10 yrs)

***OLDER THAN 65 YEARS OLD ONLY*:**

Bone Density Test: M\_\_\_\_/D\_\_\_\_/Year\_\_\_\_\_\_\_

***PAST SURGICAL HISTORY***: [ ] None

Surgery Reason Year

|  |  |  |
| --- | --- | --- |
|   |  |  |
|  |  |  |
|  |  |  |

***SOCIAL HISTORY***: Smoker? Never/Former/Current. If formerly or currently smoking, please answer the following questions.

Tobacco: \_\_\_\_\_\_\_ pack/day How old were you when you started smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Alcohol: \_\_\_\_\_\_ drinks/week/month [ ] Caffeine intake: none/Moderate/Heavy

 [ ] other Drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FEMALE ONLY*:** Date of last period: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ How old were you when you menarche?\_\_\_\_\_\_

[ ] Menopause Age?\_\_\_\_\_\_\_\_ [ ] Are you pregnant? Age at first child?\_\_\_\_\_\_\_\_

[ ] Are you nursing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FAMILY HISTORY***: Do you know anyone in your **family** with the following problem? [ ] No

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Sister | Brother | Mom’s mom | Mom’s dad | Dad’s mom | Dad’s dad | Other |
| Alive |  |  |  |  |  |  |  |  |  |
| Deceased |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Diseases/Conditions** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |  |
| Alzheimer |  |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |
| Emphysema (COPD) |  |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |
| Thyroid |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |

Additional info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Preferred Pharmacy:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Registration Information**

|  |
| --- |
| ***PATIENT’S PERSONAL INFORMATION*:** **Sex:** [ ] Male [ ] Female **Marital Status:** [ ] Single [ ] Married [ ] Divorced [ ] WidowedPatient Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Race**: [ ] Asian [ ] Native Hawaii/Pacific Islander [ ] Black/African American [ ] White [ ] Hispanic [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Decline**Ethnicity**: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Latino [ ] Decline**Language**: [ ] English [ ] Spanish [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***PATIENT/RESPONSIBLE PARTY INFORMATION*:**Relationship to Patient [ ] Self [ ] Spouse [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_Home Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Assignments of Benefits \* Financial Agreement:**

I hereby give authorization for payment of insurance benefits to be made directly to East Lake Medical Clinic, PA., Dr. Dustin Ly and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collections, and reasonable attorney’s fees. I hereby authorize this healthcare provider to release any and all information necessary to secure the payment of benefits.

I acknowledge the above statement. Please sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Missed Appointment Policy**: Please kindly give us a 24hr notice if you cannot attend a scheduled appointment or wish to reschedule. A $25 fee will be charged for any missed appointment without prior notice. We thank you for your understanding.

I acknowledge the above statement. Please sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**With this consent, East Lake Medical Clinic, PA** may also call my home or cell and leave a message on voicemail or in person in reference to any item that assist the clinic in

carrying out healthcare operation, such as appointment reminders, insurance information and any calls pertaining to my clinical care, including laboratory results among others.

I hereby give my consent for East Lake Medical Clinic, PA to use and disclose protected health information (PHI) about me to carry out healthcare operations (i.e treatment, diagnostic procedures, and payment).

Who can we talk to about your medical condition if something happens to you? Release my Protected Health Information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, East Lake Medical Clinic, PA may decline to provide treatment to me.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

I agree to using tele-video visits. I understand and agree that this conversation may contain your personal health information and acknowledge that I am not responsible for the privacy policies

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

PATIENT AUTHORIZATION FOR THE RELEASE OF BILLING INFORMATION

Patient or patient representative should review the following disclosure carefully regarding the release of Protected Health Information (PHI) for insurance billing purposes. Please retain a copy of the completed form for your records.

1. Our office follows HIPAA regulations in regards to protecting your private health care information. As such, we must have each patient’s written consent to release Protected Health Information (PHI) to any outside agency. Our office uses an outside billing agency to file our insurance claims. If you would like us to file your insurance for services provided, we must release your demographic and insurance information to our billing agency in order to do this. Our billing agency is also bound by the same HIPAA regulations and will release only the minimal information required by your insurance carrier(s) in order for your claim(s) to be processed. If this is acceptable to you, please sign below indicating that you understand this disclosure.
2. Payment for patient’s cost share (co-payments, co-insurance and deductible amounts) is normally due at the time of service unless other arrangements are made. If a balance remains after your insurance(s) processes your claim, you may receive a bill from our billing agency. This balance is payable upon receipt of your bill. If your balance becomes delinquent (over 60 days old from your last visit), our office may pursue outside intervention in order to collect any monies owed to us. To prevent this from occurring it is important that you contact either our office or our billing agency if you have questions regarding your balance.

Patient’s Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have the right to revoke this authorization in writing by submitting a written notification to our office. The revocation is not effective if the notification is received after the release of information has occurred. If you have any questions or concerns, please ask our office for assistance.

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

\* You May Refuse to Sign This Acknowledgement\*

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy

Practices or to document our good faith effort to obtain that acknowledgement.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but

acknowledgement could not be obtained because:

\_ Individual refused to sign

\_ Communications barriers prohibited obtaining the acknowledgement

\_ An emergency situation prevented us from obtaining acknowledgement

\_ Other (Please Specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **MEDICATION REFILLS POLICY**

Please help us minimize the large volume of calls daily for medication refill requests. Before your come to your regular appointment, please review your medications, diabetes supplies, inhalers etc. to determine if you need to request any new prescriptions. We allow up to 4 medications refill per visit.

We do require office visits on a regular basis for all of our patients taking prescription medication.

Our new policy will require to call in appropriate requests for prescription refills **within 3 business days**. If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit. It is your responsibility to schedule an appointment before you run out of medication. You should schedule your next visit before you leave our office.

I have read and agree to the above statement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Authorization to Release Medical Records!**

Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last), (First)

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please release my medical records to East Lake Medical Clinic. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

My records may be obtained from the following facilities/doctors:

Facility Name/Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name/Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name/Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_

This release will remain in effect as long as we are your medical provider, unless it is revoked in writing.

 Patient, Parent, or Legal Guardian, please sign below:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_