Trinity Family Physicians

Let Our Family Care for Yours

Amir Shirmohammad, MD, MPH Stephanie Eldridge, MD, MPH

1817 Cypress Brook Drive, Suite 101
Trinity, FL 34655
Phone: (727) 834 – 8377 Fax: (727) 834 – 8371

Name: _____ D.O.B: _____
Social Security #: _____ Email Address: _____
Home Address: _____City: _____ State: _____ Zip: _____
Employer: _____Occupation: _____
Home Phone: _____ Leave Message: Yes / No (call order___)
Cell Phone: _____ Leave Message: Yes / No (call order___)
Work Phone/ext: _____Leave Message: Yes / No (call order___)

Emergency Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Circle one for each category:
Do you reside in FL year round? Yes / No (If no, please fill in the following section)
Do you have an alternative PCP that takes care of your routine/yearly care? Yes / No
Alternative PCP Name: _____ Phone: _____
Home Address: _____City: _____ State: _____ Zip: _____
Months at the alternative Address: _____ to _____

Circle one for each category:
Sex: M / F **Employment Status**: FT / PT / Retired/Other **Student Status**: FT / PT
Marital Status: Married / Single / Divorced / Widowed / Legally Separated / Significant Other
Preferred Language: English / Spanish / Russian / Indian / Other
Ethnicity: Hispanic / Non-Hispanic
Race: Caucasian / African American / Hispanic / American Indian / Asian / Hawaiian / Other

Primary Insurance: _____Insured's Name: _____
Social Security #: _____ D.O.B_____ Relationship: _____
Policy / Subscriber #: _____ Group #: _____
Eligibility / Customer Service Phone: _____

Secondary Insurance: _____Insured's Name: _____
Social Security #: _____ D.O.B_____ Relationship: _____
Policy / Subscriber #: _____ Group #: _____
Eligibility / Customer Service Phone: _____

Local Pharmacy: _____Address:_____ Phone: _____

Mail Order Pharmacy: _____ Address: _____Phone:_____

Insurance Assignment & Release Form: I hereby authorize my Insurance Benefits to be paid directly to Trinity Family Physicians. I also authorize the physician to release any information required and/or requested by my insurance carrier.

Signature: _____Date: _____

Co-Pay or Payment is due upon the day services are rendered.
Cash, Check, Visa, MasterCard, Discover or American Express

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AUTHORIZATION TO OBTAIN / RELEASE MEDICAL RECORDS

I, _____ for _____
Name of Patient / Guardian Name of Patient

Date of Birth _____ Social Security Number _____

give authorization for Trinity Family Physicians to release to and / or obtain my protected health information / medical records from the following Physician and / or facility.

_____
(Name / Physician / Facility / Agency / Organization)

_____
(Complete Address)

_____
(Phone Number / Fax Number)

The purpose of the use or disclosure is (please check all that apply) :

_____ Continued Patient Care	_____ Attorney / Legal	_____ Social Service / Disability
_____ Insurance	_____ Personal Use	_____ Patient Transferring PCP
_____ Patient Moving	_____ Other:	_____ Other:

Please ONLY send LAST "2" years of the following records: OFFICE NOTES, PROBLEM LIST, IMMUNIZATION RECORDS, PERTINENT LABS, IMAGING and DIAGNOSTICS REPORTS

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials or check mark on the lines below authorize the release (if applicable) of information pertaining to:

(_____) Alcoholism and / or Drug Abuse
(_____) Mental Health and / or Rehabilitation
(_____) HIV / AIDS / Sexually Transmitted Disease & testing for other communicable diseases

I understand that this information will be used solely for professional purposes, will remain confidential and may not be discloses to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance thereon. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

_____	_____	_____
Print Patient Name	Signature of Patient/Guardian	Date
_____	_____	_____
Print Witness Name	Signature of Witness	Date

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General Office Policies / Patient Information Guide

Good Health Care - Is not like drive-through fast-food service; we will spend quality time with you as we do with all of our patients. Please allow on average about 1 -1.5 hours for your visits. Unfortunately, unexpected urgent matters arise during visits. We always try our best to provide excellent and efficient care.

Be Courteous – Please remember during your visits that other patients are waiting for you to finish with the doctor as well.

Follow Up Appointments - Please schedule your follow-up appointments before leaving the office. Even if it's a year out from now! We want you back for check-ups and tune-ups.

All Test Results - Do not assume that "no news is good news." All labs, imaging and additional testing will be discussed at your appointment. So please make sure your follow-up appointment is made prior to leaving.

Procedure Coverage - It is your responsibility to know what your plan covers for all visits at our office including: office procedures such as EKGs, pap smears, labs/urine test etc. Please check with your insurance prior to completing labs and imaging. Please be advised that most insurances designate some financial responsibility to the patient. Our responsibility is taking care of your health. Your responsibility is knowing your insurance benefits and coverage.

Controlled Medications - Controlled medications will not be filled on your first visit. We will need to obtain prior records before considering treatment options like referrals or taking over some types of medications. This is done on a case by case basis. Laws mandate patients be seen in office for these types of refills for close monitoring.

Patient Portal Set Up - We highly encourage you to provide your email as another form of communication with our office. By doing so you will be able to access your patient portal to send us refill requests and view test results after they have been discussed with you in detail at your appointment with the provider.

Refills - We highly recommend refill requests done at your office visit. Should you need refills between visits please contact our office directly NOT the pharmacy, either through your patient portal (preferred and most efficient method) or by phone at least 7 days prior to running out.

Electronic Communication Consent – By providing your email to the practice you hereby give consent to receive messages regarding your healthcare, financial responsibilities and other issues.

I have read, understand and acknowledge all of the above.

Print Patient's Name: _____Date: _____

Signature of Patient or Legal Guardian: _____

Print Name of Parent / Legal Guardian: _____

Trinity Family Physicians

Financial and Insurance Policy

Thank you for choosing Trinity Family Physicians as your health care provider. As part of our services, we require you read and sign the following financial policy prior to services being rendered. Patient or responsible party must complete our information and insurance form before seeing our physicians or nurse practitioner.

*__Payments:__ Full payment, co-payment, co-insurances and / or deductibles are due at the time services are rendered. Payment methods are: Cash, Check, and credit card. If you do not have your fees with you at the time of services we have the right to reschedule your appointment. Please bring your insurance card, driver's license and your portion to pay with you at every visit. If your account becomes delinquent requiring a referral to collections then you will be responsible for all fees incurred.

_____Initials

***Return checks:** A $50.00 service charge will be charged to your account for returned checks. Returned checks will not be re-deposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check; the account will be turned over to a collection agency. We request a copy of your driver's license for our records for verification.

_____Initials

***Office Policy:** Per our contract with each insurance policy, it is your responsibility to know your benefits. Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. Your insurance company does not guarantee your benefits until the claim is filed. If your insurance has not paid within 60 days you will be responsible for the balance. Your insurance will send you an explanation of benefits that explains what they have paid to our office. If you do not agree with their payment, please contact the insurance company directly.

_____Initials

***Appointment Cancellation Policy:** A $60.00 fee will be charged for scheduled appointments cancelled without 24 hours prior notice or if you walk out prior to being seen. Patient will also be charged for failure to show up for a scheduled appointment. If you have more than two missed no show appointments you may be dismissed from our practice.

_____Initials

***Minor Patients (under the age of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have parents or guardians written permission along with a copy of their photo I.D. prior to treatment of a minor.

_____Initials

***All Medicare Patients:** We will bill Medicare as well as secondary insurance. If you have Medicaid as a secondary insurance we will not be able to see you. If payment is not received from your secondary insurance within 60 days, you will be notified that there is an outstanding balance due. You must then contact your secondary insurance to receive reimbursement for any fees paid directly to our office. **_____Initials**

***PCP Selection:** It is your responsibility to make sure that if your insurance requires a PCP to be selected on your insurance policy that you have it switched over to one of our providers prior to your each visit and make sure our provider is the effective and current provider for you. If this is not done or not effective prior to your appointment you understand that you will be financially responsible for that visit at the time of service. This is your insurance company's policy and not ours.

_____Initials

***Policy on Physical Exams:** We do encourage physicals (well-visits) at separate visits during the month of your birthday each year. We recommend all patients to do this for preventative care and health maintenance. If you are here for a medical complaint then this visit is NOT a physical and will be billed accordingly.

_____Initials

Please realize that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. You are responsible for all charges that are denied / not covered by your insurance company. Procedures / services performed by our physicians, nurse practitioner or nurses may not be covered under your insurance plan.
3. Although we verify your coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment from your insurance company. We request that you present a copy of your insurance card for our records that is being utilized.
4. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside this office.

Print Patient's Name: _____

Date:_____

Signature of Patient or Legal Guardian:_____

Print Name of Parent / Legal Guardian: _____

Please provide a credit card or debit card for our records that may be used to cover cancellation or no show fees in the office.

Name on card:_____

Credit Card Number: _____

Expiration Date:_____/_____ CVV:_____

I have read and understand my card can potentially be charged if I fail to show up to an appointment or cancel within 24 hours of my scheduled appointment.

Print Patient's Name: _____Date:_____

Signature of Patient or Legal Guardian: _____

Print Name of Parent / Legal Guardian: _____

Trinity Family Physicians

1817 Cypress Brook Drive Trinity, Fl 34655
Office: 727-834-8377 Fax: 727-834-8371

HIPAA Consent & Notification

I hereby give my consent for **Trinity Family Physicians** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). **Trinity Family Physicians'** Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Trinity Family Physicians reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Trinity Family Physicians,** 1817 Cypress Brook Drive, Suite 101, Trinity, Florida 34655.

With this consent **Trinity Family Physicians** may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Trinity Family Physicians** may discuss my medical records with:

Name:_____Relationship:_____Telephone:_____
Name:_____Relationship:_____Telephone:_____
Name:_____Relationship:_____Telephone:_____

With this consent, **Trinity Family Physicians** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, **Trinity Family Physicians** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Trinity Family Physicians** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Trinity Family Physicians'** use and disclosure of my PHI to carry out TPO. 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, **Trinity Family Physicians** may decline to provide treatment to me.

____ **I have received a copy of Trinity Family Physicians' Notice of Privacy Practices.**
Initial

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____

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 the Privacy Official for
Trinity Family Physicians
727-834-8377

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Trinity Family Physicians, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit Trinity Family Physicians, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Trinity Family Physicians, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Trinity Family Physicians is required to:
1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Trinity Family Physicians, reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.
Examples of How Trinity Family Physicians may use or disclose your health information:

For Treatment: Trinity Family Physicians, may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: Trinity Family Physicians, may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Appointments: Trinity Family Physicians may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose 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 health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant
Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Trinity Family Physicians, may use and disclose information about you as required by law. For example, Trinity Family Physicians may disclose information for the following purposes:

For judicial and administrative proceedings pursuant to legal authority;
To report information related to victims of abuse, neglect or domestic violence; and
To assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Official at:

Trinity Family Physicians
1817 Cypress Brook Drive
Suite 101
Trinity, FL 34655

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Trinity Family Physicians is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Trinity Family Physicians

Name of Patient (please print)_____

_____ _____

Signature of Patient or Authorized Representative Date

Trinity Family Physicians

Let Our Family Care for Yours

Clinical Summary

Welcome to our practice. Please answer all the questions found below to the best of your ability.

Name: _____ **Date:** _____

Reason for today's visit: _____

Allergies to any medications: _____

Previous Hospitalizations/Surgeries/Procedures:	When:	Doctor:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a colonoscopy: YES or NO If so, when: _____ Doctor_____

FOR WOMEN ONLY

1. Last Pap Smear: _____ Do you have a GYN: _____ If so, who_____
2. Are your periods normal: _____
3. Last menstrual period: _____
4. Number of pregnancies:_____ vaginal deliveries: _____C-Sections: _____
5. Last Mammogram: _____
6. Last Bone Density Screening: _____

_____

Initials

Trinity Family Physicians

Let Our Family Care for Yours

Medication List for: _____

Please list your current medications:

❑ **Currently, I am NOT on any medication.**

Name	Strength	Cap/Tab/Other?	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

_____
Initials

Trinity Family Physicians

Let Our Family Care for Yours

PATIENT HISTORY SHEET

Name: _____

PAST MEDICAL HISTORY:

- ☐ ABDOMINAL AORTIC ANEURYSM
- ☐ ABNORMAL PAP SMEAR (female)
- ☐ ATTENTION DEFICIT DISORDER
- ☐ ADOPTED
- ☐ ALLERGIC RHINITIS
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BACK PAIN
- ☐ BLOOD TRANSFUSION
- ☐ BENIGN PROSTATIC HYPERTROPHY
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ CANCER: BLADDER
- ☐ CANCER: BONE
- ☐ CANCER: BREAST
- ☐ CANCER: COLON
- ☐ CANCER: LEUKEMIA
- ☐ CANCER: LUNG
- ☐ CANCER: LYMPHOMA
- ☐ CANCER: MELANOMA
- ☐ CANCER: MOUTH
- ☐ CANCER: OVARIAN (female)
- ☐ CANCER: PROSTATE (male)
- ☐ CANCER: RENAL CELL
- ☐ CANCER: SKIN
- ☐ CANCER: TESTICULAR (male)
- ☐ CANCER: THYROID
- ☐ CANCER: UTERINE (female)
- ☐ CARDIOMYOPATHY
- ☐ CARPAL TUNNEL
- ☐ CATARACTS
- ☐ CVA (STROKE)
- ☐ CHRONIC BLADDER INFECTIONS
- ☐ CHRONIC DIARRHEA
- ☐ CHRONIC PANCREATITIS
- ☐ CIRRHOSIS
- ☐ COLOSTOMY
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ CORONARY ARTERY DISEASE
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULITIS
- ☐ DIVERTICULOSIS
- ☐ DNR (DO NOT RESUSCITATE)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ EDEMA
- ☐ EMPHYSEMA
- ☐ GALLBLADDER DISEASE

_____
Initials

Name: _____

☐ GERD
☐ GOUT
☐ HEAD OR NECK RADIATION
☐ HEADACHE
☐ HEART DISEASE
☐ HEART MURMUR
☐ HYPERTENSION (High blood pressure)
☐ HERNIA
☐ HYPOTHYROIDISM
☐ HYPERLIPIDEMIA (High cholesterol)
☐ INSOMNIA
☐ MACULAR DEGENERATION
☐ MIGRAINE HEADACHE
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPENIA
☐ OSTEOPOROSIS
☐ PALPITATIONS
☐ PNEUMONIA
☐ POLIO
☐ PULMONARY NODULE
☐ PULMONARY EMBOLUS
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ SEIZURES
☐ THYROID NODULE
☐ TIA (Transient ischemic attack aka mini-stroke)
☐ ULCERS
☐ URINARY INCONTINENCE
☐ UTERINE PROLAPSE (female)
☐ VERICOSE VEINS
☐ OTHER: _____
_____

☐ NONE OF THE ABOVE

SOCIAL HISTORY:

DO YOU SMOKE? ☐ YES ☐ NO

IF YES, PACKS PER DAY: ☐ ONE ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU USE CAFFEINE? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

MARITAL STATUS:

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

_____
Initials

Name: _____

FAMILY HISTORY:

MOTHER: ☐ ALIVE ☐ DECEASED

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

FATHER: ☐ ALIVE ☐ DECEASED

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

SIBLINGS: # BROTHERS ____ # SISTERS _____

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

CHILDREN: # BOYS ____ # GIRLS _____

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

_____
Initials

Name: _____

REVIEW OF SYSTEMS:

Which of the following symptoms have you had in the past **2 weeks**?

- ☐ FEVERS OR SWEATS
- ☐ UNDESIRED WEIGHT LOSS
- ☐ VISION WORSENING
- ☐ DOUBLE VISION
- ☐ HEARING LOSS
- ☐ DIFFICULTY SWALLOWING
- ☐ CHEST PAIN
- ☐ CHEST HEAVINESS
- ☐ SHORTNESS OF BREATH
- ☐ COUGHING UP BLOOD
- ☐ BLOOD IN STOOL
- ☐ VOMITING BLOOD
- ☐ BLOOD IN URINE
- ☐ URINARY DISCHARGE
- ☐ JOINT SWELLING
- ☐ MUSCLE WEAKNESS
- ☐ IRRITATED MOLES
- ☐ CHANGING MOLES
- ☐ CONVULSIONS
- ☐ FALLING
- ☐ LACK OF PLEASURE/FUN
- ☐ THOUGHTS OF SUICIDE
- ☐ HOT FLASHES
- ☐ CAN'T TOLERATE HOT/COLD TEMP
- ☐ BRUISING EASILY
- ☐ BLEEDING FREQUENTLY
- ☐ WHEEZING
- ☐ NASAL CONGESTION
- ☐ SEX LIFE COULD BE BETTER
- ☐ SNORING

☐ NONE OF THE ABOVE

_____
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