Today's Date: _____

Patient Information

Full Name: _____ Date of Birth: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home #: _____ Cell #: _____ Email: _____

SS #: _____ Race: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender: ☐ Male ☐ Female

Employment

Employer: _____ Dept/Title: _____

Address: _____
Street Address *Phone #*

Emergency Contacts

Spouse/Companion/Guardian:

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Nearest relative or friend not living with you:

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group#: _____

Name of Insured: _____ Relationship: _____

SS#: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____ Group#: _____

Name of Insured: _____ Relationship: _____

SS#: _____ DOB: _____

Worker's Compensation ☐ **YES** ☐ **NO**

Contact Person: _____ Title: _____ Phone: _____

Billing Information

Person Responsible for Payment:

Full Name: _____ Relationship: _____ SS#: _____

Address: _____
Street Address *Phone #*

Employer: _____ Dept/Title: _____

Address: _____
Street Address *Phone #*

Referral Information

Referred by: _____ Phone: _____

Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information (MW119)

Patient Name _____ Date of Birth _____

Social Security Number _____ Primary Phone Number _____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that **I may revoke this authorization at any time by notifying Medical West** in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I hereby authorize Medical West to disclose health information to the following:

Name & Relation _____ Phone # ( ) _____

Name & Relation _____ Phone # ( ) _____

Name & Relation _____ Phone # ( ) _____

Name & Relation _____ Phone # ( ) _____

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

YES NO The physicians and staff of Medical West may confirm my appointment to my answering machine at the number provided on my patient information sheet.

YES NO The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my answering machine.

YES NO The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions _____

My signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Signature of Patient/Legal Guardian/Responsible Party _____ Date _____

Printed Name of Legal Guardian/Responsible Party _____ Relationship to Patient _____

No Show/Cancellation Acknowledgement

Applicable at all Medical West Health Centers

Printed Name of Patient _____ Date of Birth _____

I acknowledge the following:

- It is important to my health that I show up on time for my doctor's appointment.
- If I do not show up for a scheduled appointment, it may affect my health and it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify my doctor's office at least 24 hours in advance when I need to cancel an appointment.
- My doctor may choose to terminate me from this practice if I have more than two no-show occurrences at any given time.

Signature of Patient/Legal Guardian/Responsible Party _____ Date _____

Printed Name of Legal Guardian/Responsible Party _____ Relationship to Patient _____

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

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Gender: ☐ Male ☐ Female

ALLERGIES TO MEDICATIONS (include reaction type/sign/symptoms)	
1.	4.
2.	5.
3.	6.

CARE TEAM

Person, Provider, Specialist, Care Giver, DME Company, etc.	Specialty / Relation	Phone Number

MEDICAL PROBLEMS

☐ Acid Reflux	☐ Diverticulitis / Diverticulosis	☐ Pancreatitis
☐ ADD / ADHD	☐ Eczema / Psoriasis	☐ Parkinson Disease
☐ ALS	☐ Emphysema	☐ Pelvic Inflammatory Disease
☐ Alzheimer's	☐ Fibromyalgia	☐ Peripheral Artery Disease
☐ Anemia	☐ Gastrointestinal Bleed	☐ Phlebitis
☐ Aneurysm	☐ Glaucoma	☐ Pneumonia
☐ Anxiety Disorder	☐ Goiter	☐ Polio
☐ Asthma	☐ Gout	☐ Restless Leg Syndrome
☐ Atrial Fibrillation	☐ Head Trauma	☐ Retinopathy
☐ Autoimmune Disorder	☐ Heart Attack	☐ Rheumatic Fever
☐ Bipolar Disorder	☐ Heart Disease / Heart Failure	☐ Rubella
☐ BPH (enlarged prostate)	☐ Heart Valve Disorder / Murmur	☐ Schizophrenia
☐ Bladder Problem(s)	☐ Hepatitis A / B / C / Other	☐ Sciatica
☐ Blood Clot(s)	☐ High Blood Pressure	☐ Seizure Disorder
☐ Blood Disorder(s)	☐ High Cholesterol	☐ Sexually Transmitted Disease
☐ Cancer _____	☐ Irritable Bowel Syndrome	☐ Sleep Apnea
☐ Carotid Stenosis	☐ Kidney Problem(s)	☐ Stomach Ulcer(s)
☐ Chicken Pox	☐ Lupus	☐ Stroke / TIA
☐ Chronic Pain	☐ Measles	☐ Thyroid Problem(s)
☐ Colon Polyp(s)	☐ Migraine Headaches	☐ Tuberculosis
☐ COPD	☐ Multiple Sclerosis	☐ Ulcerative Colitis
☐ Dementia	☐ Mumps	☐ Vertigo
☐ Depression	☐ Neuropathy	☐ Vitamin B12 Deficiency
☐ Diabetes	☐ Osteopenia / Osteoporosis	☐ Vitamin D Deficiency

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED THAT ARE NOT LISTED ABOVE

Please turn to the next page

Patient's Name: _____

Date of Birth: _____ / _____ / _____

REVIEW OF SYSTEMS

Today's Date: _____ / _____ / _____

Please mark any symptom(s) you are currently having, or have experienced in the last two (2) weeks. If you are not having any of these symptoms please mark, "No Problems".

No Problems	

Constitutional / General Health	
Appetite change	
Excessive sweating	
Fatigue	
Fever	
Chills	
Night sweats	
Unexpected weight change	
Weight gain _____ lbs.	
Weight loss _____ lbs.	
Eyes	
Blurred vision	
Corrective lenses	
-- Contacts	
-- Glasses	
Decreased vision	
Diplopia (double vision)	
Eye irritation	
Eye pain	
Spots in vision	
Vision loss	
Ears, Nose, Mouth & Throat	
Ear pain	
Hearing loss	
Tinnitus (ringing in ears)	
Vertigo	
Facial pain	
Nasal discharge	
Nasal congestion	
Epistaxis (nose bleed)	
Postnasal drainage	
Bleeding gums	
Dental pain	
Mouth lesions	
Hoarseness	
Sore throat	
Cardiovascular (Heart)	
Chest pain	
-- At rest	
-- Upon exertion	
Decreased exercise tolerance	
Dizziness	
Dyspnea (difficult or labored breathing)	
-- At rest	
-- Upon exertion	
Orthopnea (shortness of breath when lying flat)	
Palpitations	
Pre-syncope (feeling as if you will faint)	

Cardiovascular (Heart) Cont.	
Syncope (fainting)	
Claudication (cramping pain in the leg induced by exercise)	
Leg ulcers	
Edema (swelling)	
Peripheral edema (swelling in the lower limbs)	
Respiratory	
Cough	
- Nocturnal (at night) cough	
- Productive cough	
- Nonproductive cough	
Hemoptysis (coughing up blood or blood-stained mucus)	
Shortness of breath	
Pleuritic (sudden, intense, sharp, stabbing, or burning pain in chest when inhaling or exhaling) pain	
Wheezing	
Snoring	
Apneas	
Gastrointestinal	
Abdominal pain	
Acid brash (regurgitation of saliva with some acid material from the stomach)	
Bloating	
Food intolerance	
Early satiety (feeling full after only a small amount of food)	
Fullness	
Epigastric discomfort (right below your ribs in the area of your upper abdomen)	
Nausea	
Vomiting	
Hematemesis (vomiting blood)	
Dysphagia (difficult swallowing)	
Reflux	
Heartburn	
Altered bowel habits	
Constipation	
Diarrhea	
Hematochezia (fresh blood in or with stools)	
Black stools	
Bloody stools	

Genitourinary (Kidney & Bladder)	
Change in urinary stream	
Dysuria (painful or difficult urination)	
Hematuria (blood in urine)	
Incontinence (lack of voluntary control over urination)	
Nocturia (getting up from sleep to urinate)	
Urinary frequency	
Urinary urgency	
Sexual dysfunction	
Female Patients Only	
Dysmenorrhea (painful period)	
Dyspareunia (painful intercourse)	
Vaginal discharge	
Menopausal	
Postmenopausal	
Last cycle: _____ / _____ / _____	
Male Patients Only	
Urinary dribbling	
Urinary hesitancy	
Penile discharge	
Musculoskeletal / Orthopedic	
Back pain	
Joint pain	
Joint swelling	
Limited range of motion	
Muscle aches	
Muscle weakness	
Stiffness	
Integumentary (Skin & Hair)	
Hair changes	
Lesions	
Changes in moles	
Pigment changes	
Pruritis (severe itching of skin)	
Rash	
Breast masses	
Breast skin changes	
Nipple discharge	
Neurologic (Brain & Nerves)	
Abnormal gait	
Dizziness	
Focal weakness	
Headache	
Incoordination	
Memory problems	
Numbness	
Numbness in feet	
Continued on next column	

Neurologic (Brain & Nerves)	
Numbness in hands	
Paresthesia (tingling, pricking, pins & needles) in feet	
Paresthesia (tingling, pricking, pins & needles) in hands	
Seizures	
Slurred speech	
Tremor	
Psychiatric (Mood & Thinking)	
Anxiety	
Decreased concentration	
Depression	
Dizziness	
Irritability	
Panic attacks	
Sleep disturbances	
Sadness/tearfulness	
Endocrinological (Glands)	
High blood sugar	
Low blood sugar	
High cholesterol	
Polydipsia (abnormally great thirst)	
Polyphagia (excessive hunger or increased appetite)	
Polyuria (frequent urination)	
Cold intolerance	
Heat intolerance	
Hematologic (Blood / Lymph)	
Bruising	
Bleeding tendencies	
Lymphadenopathy (enlarged lymph nodes)	
Recurrent infections	
Allergic / Immunologic	
Eczema	
Seasonal allergies	
Urticaria (hives)	
Any Symptoms not listed:	

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

SOCIAL HISTORY								
Marital status	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed		
	Do you live alone? ☐ Yes ☐ No	If no? ☐ With Family	☐ With Spouse	☐ Other				
Employment	☐ Full Time	☐ Part Time	☐ Homemaker	☐ Retired	☐ Disabled	☐ Student	☐ Other	
	Current Occupation:							
	Past Occupation:							
Advanced Care Planning	Do you have an Advance Directive and/or Living Will? ☐ Yes ☐ No							
	If yes, where is it kept?							
	If no, would you like information on Advance Directives? ☐ Yes ☐ No							

HEALTH HABITS AND PERSONAL SAFETY
All questions contained in this questionnaire will be kept strictly confidential.

Alcohol	Do you drink alcohol? ☐ Yes ☐ No		
	What kind?	How much?	How often?
Drug Use	Do you currently use recreational or street drugs ☐ Yes ☐ No		
	What kind?	How much?	How often?
Exercise	☐ No routine/regular exercise		
	☐ Routine/regular exercise		
	What kind?	How much?	How often?
Tobacco Use	Do you currently, or have you ever used tobacco products? ☐ Yes ☐ No		
	☐ Current Tobacco User	☐ Former Tobacco User	
	What kind of tobacco?	How much?	How Often?
	Start date / age / year:	Quit date / age / year:	

FAMILY MEDICAL HISTORY

Relation	Cancer *List Type*	Alzheimer's and/or Dementia	Heart Disease and/or High Blood Pressure	Heart Attack and/or Stroke	Diabetes	Autoimmune Disease *List Type*	Vascular or Arterial Disease (CAD, CVD, PVD, PAD, etc.)	Asthma, CHF, other Lung Disease
Adopted: ☐ Yes ☐ No								
Mother								
Father								
Brother 1								
Brother 2								
Sister 1								
Sister 2								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								

LIST ANY SIGNIFICANT HEALTH PROBLEMS THAT ARE NOT LISTED ABOVE

SURGICAL HISTORY

Date / Age	Surgery (example: left knee replacement)	Date / Age	Surgery (example: gallbladder removed)

Please turn to the next page

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

IMMUNIZATION HISTORY – IF A "BLUE CARD" OR CHILDHOOD IMMUNIZATION HISTORY IS AVAILABLE PLESE PROVIDE A COPY			
☐ Hepatitis A	☐ Completed	☐ Pneumococcal Polysaccharide (PPSV23)	Date
☐ Hepatitis B	☐ Completed	☐ Tetanus, Diphtheria, Pertussis (Tdap)	Date
☐ HPV (2, 4, or 9)	☐ Completed	☐ Tetanus, Diphtheria) Td	Date
☐ Influenza (Flu Vaccine)	Date:	☐ Varicella (Chickenpox)	☐ Completed
☐ Measles/Mumps/Rubella (MMR)	☐ Completed	☐ Zoster Live (Zostavax)	Date
☐ Meningococcal (meningitis)	☐ Completed	☐ Zoster Recombinant (Shingrix)	☐ Completed
☐ Pneumococcal Conjugate (PCV13)	Date	☐ Other:	
PREVIOUSLY PERFORMED TESTS AND SCREENINGS			
☐ Colonoscopy	Date	☐ Pap Smear ☐ with HPV	Date
☐ Cologuard	Date	☐ GYN Check Up	Date
☐ DEXA – Bone Density	Date	☐ PSA	Date
☐ Dilated Eye Exam	Date	☐ Hemoglobin A1c	Date
☐ Fecal Occult Blood (stool card)	Date	☐ TB Skin Test	Date
☐ Lipid / Cholesterol Level	Date	☐ Other:	Date
☐ Mammogram	Date	☐ Other:	Date

CURRENT MEDICATIONS

Prescriptions, Over the counter, Vitamins, Supplements, Injections, Birth Control, Implants, Chemotherapy, etc.

Medication Name	Strength	Frequency Taken

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Location	Pharmacy Phone Number