Welcome to Our Office

New Patient

Date of Appointment:_____

Patient Name:_____

Who are you scheduled to see today? (check one)

☐ Dr. Knudsen

☐ Dr. Manfredi

☐ Dr. Hope

☐ Judith Garrett, NP

☐ Jen Castro, NP

☐ E. Lynne Carey, NP

☐ Zoryana Bosak, NP

How did you hear about Preventive Medicine Associates?

☐ Family Member (name: _____)

☐ Friend (name: _____)

☐ Patient (name: _____)

☐ Insurance Company

☐ Internet

☐ Radio Advertisement

☐ Word of Mouth

☐ Marketing

☐ TV Commercial

☐ Hospital (Hospital name: _____)

☐ Other Doctor's Office (Doctor's name: _____)

PREVENTIVE MEDICINE ASSOCIATES, PLLC www.preventive-med.net

PO Box 370 • 5415 West Genesee Street • Suite 301 • Camillus, NY 13031 • Phone (315) 487-8109 • Fax (315) 487-5680

PATIENT REQUEST FORM:
ASSIGNMENTS AND RELEASE OF PATIENT INFORMATION AGREEMENT

Patient Name:_____

RELEASE OF INFORMATION

I hereby authorize and direct Preventive Medicine Associates, PLLC having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

ASSIGNMENT OF BENEFITS AGREEMENT

I hereby assign, transfer and turn over to Preventive Medicine Associates, PLLC sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered by myself.

GUARANTEE ON ACCOUNT

In consideration of admission of the above named patient, I agree to be bound by all the rules of Preventive Medicine Associates, PLLC, and guarantee to pay promptly at established rates. Should this case be Workers' Compensation or a Third Party insurance case, I agree to pay all expenses not assumed by such agency or insurance carrier. I agree to pay fees related to the collection of a balance on my account including collection agency fees.

MEDICARE CERTIFICATION (WHEN APPLICABLE)

Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Section XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____

Patient Signature and/or Representative: Date:

PATIENT CONSENT TO USE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____

I consent to the use of my Protected Health Information (PHI) by **Preventive Medicine Associates, PLLC** ("the Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations of the Practice.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the Practice. The Practice is not required to agree to the restrictions that I may request. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician another health care provider, a health plan, my employer or a health care clearing house. This PHI information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Practice. The Notice of Privacy Practices also describes my rights and the Practice's duties with respect to my PHI.

I understand that the Notice of Privacy Practices is posted in the waiting room. The Practice reserves the right to change the Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices by asking the receptionist during regular business hours.

PLEASE LIST BELOW THE NAMES AND RELATIONSHIP OF THOSE INDIVIDUALS PERMITTED ACCESS TO YOUR PHI:

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature and/or Personal Representative Date

_____

Print Name of Patient and/or Personal Representative

PREVENTATIVE MEDICINE ASSOCIATES, PLLC

HIPPA COMPLIANCE FORM

New York State Health Care Proxy Form

1. I, _____ hereby appoint

(name, address and telephone number)
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

2. Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section.

3. Name of substitute or fill-in-agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

(name, address and telephone number)

4. Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

5. Signature:_____

Address:_____

Date:_____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting on his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1:_____ Date:_____

Address: _____

Witness 2:_____ Date:_____

Address: _____

Preventive Medicine Associates

HealtheConnections

HealtheConnections™ Consent Form
Preventive Medicine Associates

In this Consent Form, you can choose whether to allow **Preventive Medicine Associates** to obtain access to your medical records through a computer network operated by HealtheConnections™, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow **Preventive Medicine Associates** to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, **Preventive Medicine Associates'** staff involved in my care may see and get access to all of my medical records through HealtheConnections™."

If you check the "**I DENY CONSENT**" box below, you are saying "No, **Preventive Medicine Associates** may not be given access to my medical records through HealtheConnections™ for any purpose."

HealtheConnections™ is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask **Preventive Medicine Associates** for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

☐ **I GIVE CONSENT for Preventive Medicine Associates to access ALL of** my electronic health information through HealtheConnections TM in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for Preventive Medicine Associates to access** my electronic health information through HealtheConnections TM for any purpose, even in a medical emergency. **NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HealtheConnections TM.**

_____ _____
Print Name of Patient Patient Date of Birth

_____
Other Names Used by Patient (e.g., Maiden Name)

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Preventive Medicine Associates, 5415 W. Genesee St. Suite 301, Camillus NY 13031 P: 315-487-8109 F: 315-487-5680

9(a) Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: Last Complete Exam, BW, EKG, ETT, Mammo, PAP, Medication List, Allergies, Immunizations, Colonoscopy, and all X-rays.

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other: Transfer of Care, Coordination of Care	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Preventive Medicine Associates

OFFICE and FINANCIAL POLICIES

Office Policy

Confirmation of Appointments

Confirmation of your appointment is mandatory. Initial calls are made by our automated system and/or sent to you as an email reminder (if you have provided your address to us) three days in advance. If you are unavailable to respond, call the office to confirm. Complete Exam appointments not confirmed by 3 p.m. the day before will be cancelled and the patient will need to reschedule as soon as possible.

Arriving for Your Appointment

New patients should plan on arriving 30 minutes before your scheduled appointment. Established patients should arrive 15 minutes before. All patients will need to update and verify demographic and insurance information. Valid state identification is also required. These tasks need to be completed before your appointment to ensure you are seen on time. Arriving late for your appointment affects every patient seen by our provider after your appointment. Therefore, patients arriving late may have a delay in being seen or will be rescheduled.

No Show and Cancellation Policy

Established patients who cancel their appointment without 24 hour notice or do not show can expect a fee of $50.00 for office calls and $75.00 for physicals and special procedures charged to their account. New patients who cancel their appointments without 24 hour notice or do not show will have a fee of $75.00 for office calls and $125.00 for physicals assessed. Our office needs at least this amount of time to fill your time slot with another patient who needs that valued time with their provider. This fee will need to be paid before your next appointment can be scheduled. We understand there may be extenuating circumstances. Please call the office as soon as possible. Be advised that multiple no shows may lead to dismissal from the practice.

Referrals

PMA will process referrals generated by your provider for our patients except for Psychology, Psychiatry and Detoxification programs. PMA is not responsible for patients who schedule their own appointments without obtaining a referral from us.

Forms

A fee of $15 per form is due when brought in or sent to the office for completion outside a scheduled appointment. Your form will not be completed until payment is made. Allow 10 business days for completion.

Patient Compliancy

The practice reserves the right to discontinue the physician/patient relationship due to patient non-compliance regarding medical and/or office policies. This includes, but is not limited to, excessive no shows, not returning phone calls to the practice for appointments or continued rescheduling of such appointments. Please note that once a patient is discharged from the practice, our office policy reads we do not reinstate a patient back into the practice.

As a reminder, our patients are expected to be seen at regular intervals, especially when on maintenance medications. These intervals will be determined by your primary provider.

Patient disrespect to staff or providers is not tolerated and will result in the discontinuation of the physician/patient relationship.

Prescription Refills

All patients are expected to call their pharmacy of choice when in need of medication refills. Your pharmacy will electronically send an e-script to your provider for your refills. All controlled substance refills are to be filled only during a face to face visit with one of our providers, for each refill. (Please see our controlled substance policy agreement.)

As a reminder, our patients are expected to be seen at regular intervals, especially when on maintenance medications. These intervals will be determined by your primary provider.

Release of Records

We require a HIPAA compliant records release to be completed and signed by the patient in order to obtain or forward records to a previous or new provider of care. When sending records to a new provider, a charge of .75 cents per page will be billed to you. Records will be released once payment has been made to Preventive Medicine Associates.

Financial Policy

It is the patient's responsibility to ensure that we participate with their insurance carrier prior to an appointment. Since each insurance carrier has multiple plans that can vary with employer group contracts, we cannot always tell you in advance whether your charges will be covered. Any remaining balance is the patient's responsibility.

You must present your insurance card(s) at every visit. Failure to present correct insurance information within 60 days will result in patient responsibility charges. Your copay, deductible and co-insurance balances are due at time of service. Failure to pay at time of visit will result in an additional fee of $20.00 added to your account.

Self-Pay Patients

Self-pay patients are required to set up payment arrangements with the Billing Dept. staff prior to your appointment.

Statements

You will receive a statement for any balance due after your insurance carrier pays. If 60 days have lapsed without payment, a $50.00 administrative fee will be added and your account will be referred to our Collection Agency. If you have not contacted our Billing Department within 60 days of being referred to our collection agency, you will be discharged from the practice. Please note that once a patient is discharged from the practice, our office policy reads we do not reinstate a patient back into the practice.

In consideration of financial hardship situations, we require contact with our Billing Department to establish a payment plan within 30 days. You will be given a contract to sign explaining our payment plan options.

Patient Signature _____ Date_____

November 19, 2012

Dear Patient,

As of January 1, 2013, Preventive Medicine Associates is adopting a new policy regarding controlled substances. This policy will be in effect for any pain medicine, any narcotic, or drug that is listed as a "controlled substance." The two exceptions being hormone replacement therapy, i.e., testosterone, and patients in hospice. Controlled substances include but are not limited to such drugs as Lortab, hydrocodone, Ambien, Ativan, Xanax, Valium, Adderall, OxyContin, etc. Any drug that requires a special prescription, or is labeled a Class II or Class III drug by the New York State Department of Pharmacy is included in this list.

We adopt this policy in part due to New York State's impending I-Stop program and in part due to recommendations from the pain clinics, our malpractice team and our governing organizations including the Department of Health, the American Medical Association, the Drug Enforcement Agency, The Workers' Compensation Board, etc. We believe that you will find more and more office practices, if they have not already done this, will adopt the same protocol. Our protocols are based on currently existing programs used by the Pain Clinics and by other private practices.

The bottom line is that every time you want a prescription or a refill for a controlled substance, you have to do this during an office call. This can be done during a routine office call for hypertension, diabetes check, etc. But, if you don't have an appointment scheduled, you'll have to make an appointment and see a provider to review this prescription. Not just pick up the prescription at the counter, but actually have a face-to-face meeting with a provider to review the use of your meds. There will be no exceptions except for people in hospice, or taking testosterone replacement. This will give us a chance to:

1) Review your medications with you and make sure they are not being misused, that they are still necessary and still appropriate, etc.
2) This will also make sure that we maintain compliance with the government's new regulations.
3) This will give us an opportunity to review the ongoing use of these medicines with you.
4) This will end, once and for all, any issues regarding scripts being lost in the mail, not received, etc.

You may end up being on more medicine, taking the same medicine for years or, in fact, cutting down the medicines over time, which is what our intent and hope is. All of us at Preventive Medicine Associates have increasing worries over the use, misuse, etc., of these controlled substances. This is a national and local issue. We do not make this change based on some problem we have had in the past. We have never been fined by any government agency. We have never been sanctioned about our use of these drugs. This is

not done because we have been found guilty of some problem and, therefore, have to stop prescribing. This is done to:

1) Maintain patient safety.
2) Maintain regulatory compliance.
3) Minimize, over time, the use of these drugs on a chronic basis.

Along with having to see a physician or nurse practitioner with every prescription renewal, we are going to ask all patients taking these medicines to sign a Pain Management Agreement. This is exactly what pain clinics do. A copy of the Pain Management Agreement is enclosed. It is, we think, fairly straightforward. Again, we think this change is in the best interest of both the practice and the patient. Additionally, there will be no prescribing of a 90-day supply or automatic refills. Any and all prescriptions for controlled substances will only be renewed for 30 days.

If you disagree with our pain management decisions, you are free to have your pain medicines prescribed by some other doctor. That does not bother us at all. That means someone else is responsible, someone else is in charge, someone else will be reviewing this. We are still happy to take you as regular patients if you have your pain medicines managed elsewhere, but we cannot and will not write you p.r.n. prescriptions because that would violate your pain agreements with other providers. To reiterate, our practice regarding controlled substances is going to include a signed pain management agreement and limit the use of these drugs to a 30 day supply and require patients to have an office call to get a refill. You do not have to have a separate office call. If you have an office call scheduled for a sore throat or routine check of your blood pressure, etc., we can accommodate this during the same visit.

Again, for the safety of the practice, for the safety of patients and to be consistent and fair to everyone, there will be no exceptions. If you would like to discuss this with an office call to sit down and review this, we are more than happy to do so but, please, do not ask us to make exceptions. There will be no exceptions to this new pain management rule. This practice represents our adoption of the stricter new guidelines which are again recommended by a variety of organizations. We will be happy to discuss this with you in person. We would be happy to have you write to us if you feel it necessary.

WE WILL NOT DISCUSS THIS OVER THE PHONE.

We understand that some patients will find this practice onerous and will seek medical care elsewhere. We accept that. We urge you, before you terminate your relationship with us, that you check with another provider to:

1) Make sure they are taking new patients.
2) Make sure that they will provide these medicines for you.

We intend to initiate this policy January 1, 2013, and there will be no exceptions to this policy except as noted for hospice patients. We hope you understand the reasons for this transition and, in the end, we hope that it is going to improve patient safety and patient health, both of which are important goals in our practice.

Sincerely,

The Staff at
Preventive Medicine Associates

JTB/ats:spd/rnw
T: 11/20/2012

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Communicable Disease Control

CONSENT FOR PARTICIPATION IN NYSIIS FOR INDIVIDUALS 19 YEARS OF AGE OR OLDER

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of you immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-4437.

I give my consent for PREVENTIVE MEDICINE ASSOCIATES, PLLC (name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in NYSIIS may be released to the following: myself, my health maintenance organization, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

_____ _____
Print Name Date of Birth

_____ _____
Signature Date

PREVENTIVE MEDICINE ASSOCIATES, PLLC

PO Box 370 • 5415 West Genesee Street • Suite 301 • Camillus, NY 13031 • Phone (315) 487-8109 • Fax (315) 487-5680

JOSEPH T. BARRY, MD
Board Certified
Internal Medicine &
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ALEXANDER B. KNUDSEN, MD
Board Certified
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DAVID C. MANFREDI, MD
Family Practice

JUDITH C. GARRETT, BSN, NP
Nurse Practitioner

JENNIFER CASTRO, FNP
Nurse Practitioner

REBECCA L. FLOOD, FNP
Nurse Practitioner

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND THE FOLLOWING

Patient Name (please print)_____

I, _____, whose signature appears below, authorize Preventive Medicine Associates, PLLC and its affiliated providers to view the external prescription history via the RxHub service for the patient listed below.

I understand that a prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff of Preventive Medicine Associates, PLLC and may include past prescriptions from several years ago.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTAND AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

_____	_____	_____
Signature of Patient or Guardian	Date	If Guardian, Relationship to Patient
_____	_____	
Witness to Signature	Date	

NAME DOB

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Thank you.

Main reason for today's visit: _____

Other concerns: _____

_____

Please list any other providers you see & their specialty: _____

_____

_____

MEDICATIONS: Please list **ALL** prescriptions & over the counter medications that you are currently taking.

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES: ☐ None ☐ Yes (If yes, to what & what reaction?) _____

_____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella(Chicken Pox) shot *or* illness _____

Pneumovax (pneumonia) _____ Prevnar _____ Influenza (flu shot) _____ MMR _____

Hepatitis A _____ Hepatitis B _____ Zostavax (shingles) _____ HPV_____ Meningitis _____

NAME DOB

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy or Colonoscopy (circle one) Date _____ Results: Abnormal? ☐No ☐ Yes ☐ Polyp

Mammogram: Most recent date/where _____ Result: Abnormal? ☐ No ☐ Yes

Pap smear: Most recent date/where _____ Result: Abnormal? ☐No ☐ Yes

Bone density Most recent date / where _____ Result: Abnormal? ☐ No ☐Yes

Last eye exam: When? _____ Where? _____

PERSONAL MEDICAL HISTORY: Do have, or have you had, any of the following?

Acid Reflux (Heartburn/Gerd)		Depression		Kidney Disease/ Failure/ Dialysis	
Alcohol / Drug Abuse		Diabetes (adult onset)		Kidney Stones	
Allergy (Hay Fever)		Diabetes (childhood)		Leukemia	
Alzheimer's / Memory Loss		Diverticulosis		Liver Disease	
Anemia		Edema		Migraine Headaches	
Anxiety		Emphysema (COPD)		Osteoporosis	
Arthritis (Osteoarthritis)		Excessive Bleeding		Pneumonia	
Arthritis (Rheumatoid)		Factures/Broken Bones		Prostate Problems	
Asthma		Gallbladder Disease		Radiation Treatments	
Atrial Fibrillation		Genital Herpes		Rheumatic Fever	
Bladder / Kidney Problems		Glaucoma		Seizures / Epilepsy	
Bleeding Problems		Gout		Sexually Transmitted Disease	
Blood Clots, If yes where?		Gynecological Conditions		Shingles	
Blood Transfusion		Heart Pace Maker		Sickle Cell Disease	
Breast Lump (Benign)		Heart Valve Problems		Skin Condition	
Cancer, If yes what kind?		Hepatitis		Sleep Apnea	
Cataracts		Herpes		Stomach Ulcer	
Chicken Pox		High Blood Pressure		Stroke	
Colon Polyp		High Cholesterol		Thyroid Disease	
Coronary Artery Disease / Heart Attack		Irritable Bowel Syndrome		Yellow Jaundice	

SURGICAL HISTORY: Please list any surgeries you have had and when. _____

_____

_____

TOBACCO USE:

☐ Smoker - packs per day? _____ ☐ Nonsmoker If quit, when? _____

FAMILY HISTORY: Adopted? ☐ No ☐ Yes If adopted & you do not know your family history skip the family history section.

NAME DOB

Indicate which relative has had the following diseases. Write the number of siblings in the appropriate boxes*. If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	Father	Sister(s)*	Brother(s)*	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad		
Alive										
Deceased										
Age Currently or at death										
Diseases & Conditions	Mother	Father	Sister(s)*	Brother(s)*	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Blood Relatives (list relationship to you)	List age(s) at diagnosis if known & if this was the cause of death
No significant history known										
Hypertension-High Blood Pressure										
Hyperlipidemia –High Cholesterol										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type II (Adult Onset)										
Cancer, Breast										
Cancer – Type										
Alzheimer's										
Autoimmune Disease										
Bleeding & Clotting Disorder										
Colon Polyp										
Diabetes Type I (Childhood Onset)										
Emphysema (COPD)										
Osteoporosis										
Depression										
Alcoholism / Drug Abuse										
Genetic Disorder (Explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis										
Hip Fracture										
Hypothyroidism/ Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other (List)										