Medical History

Today's Date: **/ /**

Name: **Chart #**

Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.) ❑ **None**

Drug name	How many times a day?	mg (Dosage)	Drug name	How many times a day?	mg (Dosage)

Past and Current Medical History

Please place "X" on any problems you have had in the past or problems you are having currently.

1 __ High blood pressure
2 __ High cholesterol
3 __ Diabetes
4 __ Asthma
5 __ Allergies/allergic rhinitis/Hay fever
6 __ Cancer
7 __ Heart disease
8 __ Ulcers
9 __ Hemorrhoids
10 __ Colitis
11 __ Hepatitis
12 __ Hyperthyroidism (too much thyroid hormone)
13 __ Hypothyroidism (too little thyroid hormone)
14 __ Migraines
15 __ Kidney diseases
16 __ Arthritis
17 __ Low back pain
18 __ Anxiety
19 __ Depression or __ **NONE**
20 __ Anemia
21 __ Alcohol abuse
22 __ Drug abuse
23 __ Gout
24 __ Other, please name.

Do you have allergies to any medication?

❑ No ❑ Yes If yes, fill out below.

	Medication	**Symptom**
1		
2		
3		
4		

Have you had any operations?

❑ No ❑ Yes If yes, fill out below.

	Year
Tonsillectomy	
Hernia Repair	
Wisdom Teeth Removal	
Other:	

Have you ever been hospitalized overnight?

(ER visits without admission or Child Birth do not count.)

❑ No ❑ Yes If yes, fill out below.

Problem	Year

Did/do your relatives have any medical problems?

For Example…. Cancer, High Blood Pressure, Diabetes, Stroke, Heart attack, Depression

Relative	Year of Birth			Problems (year started)		
Father		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Mother		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Brothers		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Sisters		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Paternal Grand Father		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Paternal Grand Mother		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Maternal Grand Father		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )
Maternal Grand Mother		❑ No	❑ Yes	1. ( )	2. ( )	3. ( )

NEXT PAGE PLEASE

Medical History

Today's Date: **/ /**

List your children and the year they were born. ❑ **None**

	Child Name	Gender M/F	Birth Year	Medical Problem No/Yes (explain)
1		M/F		❑ No ❑ Yes
2		M/F		❑ No ❑ Yes
3		M/F		❑ No ❑ Yes
4		M/F		❑ No ❑ Yes

Complete your Social History.

1 Are you a : ❑ never smoker---skip to question #2 ❑ former smoker ❑ current smoker

* If **former smoker**, how long has it been since you last smoked?

❑ <1 month ❑ 1~3 months ❑ 3~6 months ❑ 6~12 months ❑ 1~5 yrs ❑ 5~10 yrs ❑ >10 yrs

* If **current smoker**, do you smoke everyday? ❑ No ❑ Yes

* If **current smoker**, how many cigarettes a day do you smoke? _____

* If **current smoker**, when is your first cigarette from the time you wake up in the morning?

❑ 5min ❑ 6~30min ❑ 31~60min ❑ after 60min

* If **current smoker**: ❑ You are ready to quit. ❑ Thinking about quitting. ❑ Not ready to quit.

* If **current smoker**, would you like us to fax your information to a smoking counselor to help? ❑ No ❑ Yes

2 Did you have a drink containing alcohol in the past year ? ❑ No---skip to question #3 ❑ Yes

* If yes, how often did you have a drink containing alcohol in the past year?

❑ Never ❑ Monthly or less ❑ 2~4 times a month ❑ 2~3 times a week ❑ 4 or more times a week

* If yes, how many drinks did you have on a typical day when you were drinking in the past year?

❑ 1~2 ❑ 3~4 ❑ 5~6 ❑ 7~9 ❑ 10 or more

* If yes, how often did you have 6 or more drinks during one occasion in the past year?

❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

3 Do you use drugs? (marijuana, cocaine, crack, etc.) ❑ No ❑ Yes **If yes, explain:** _____

4 What is your occupation? _____

5 If you had sex with someone, it will be with members of the:

❑ Opposite Sex ❑ Same Sex ❑ Both ❑ Neither

6 You are ❑ Single or ❑ Married

If single, ❑ Divorced ❑ Spouse died ❑ Live with a partner ❑ None of these

7 Name of your spouse or partner, if any.

First Name Last Name

_____

8 When was your last Pap Smear? _____

Have you ever had an abnormal Pap Smear result? ❑ No ❑ Yes **when/type** _____ /

I agree to share my immunization records with NY Citywide Immunization Registry (CIR). ❑ Yes ❑ No

City Care Family Practice, P.C. 461 Park Ave South, 9th Fl NYC 10016 212-545-1888

update 7/24/19

Today's visit is related to:

- ❑ A car accident
- ❑ An incident at work
- ❑ None of the above

Do you have a form(s) to be filled out?

- ❑ Yes ❑ No

1.What is your main problem/symptom today:

2.When did your problem/symptom start: __ Days __ Weeks __ Months __ Years ago

3.Location of symptoms/problem :

4.Timing of problem/symptom: ❑ Gradual ❑ Intermittent ❑ Sudden

5.Describe how intense is the problem/symptom: ❑ Mild ❑ Moderate ❑ Severe

6.What makes the problem/symptom worse:

7.What makes the problem/symptom better:

Medications

Prescription or over-the-counter that you are currently taking. ❑ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Depression Screening (Circle Yes or No)

Little interest or pleasure in doing things? Yes No

Feeling down, depressed or hopeless? Yes No

Mark any symptoms you are currently having, or mark the normal box.

General ❑ Normal

- ❑ Fever
- ❑ Swollen glands
- ❑ Body ache
- ❑ Chills
- ❑ Weight loss
- ❑ Weight gain
- ❑ Nervousness/Anxiety
- ❑ Trouble sleeping
- ❑ Fatigue

Head ❑ Normal

- ❑ Headaches
- ❑ Head injury

Nose,Throat & Mouth ❑ Normal

- ❑ Sore throat
- ❑ Hoarseness/Lost voice
- ❑ Nasal stuffiness
- ❑ Mucous dripping behind nose into throat
- ❑ Runny nose
- ❑ Nose bleeds
- ❑ Snoring
- ❑ Facial/ Tooth pain

Ears ❑ Normal

- ❑ Hearing problem
- ❑ Pain
- ❑ Drainage
- ❑ Ringing

Eyes ❑ Normal

- ❑ Vision problem
- ❑ Pain
- ❑ Double vision
- ❑ Itchy
- ❑ Red
- ❑ Crusty

Skin ❑ Normal

- ❑ Itching
- ❑ Rash

Heart ❑ Normal

- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Swollen feet

Lungs ❑ Normal

- ❑ Trouble breathing
- ❑ Cough
- ❑ Spitting up blood
- ❑ Wheezing
- ❑ Unable to sleep due to cough

Digestive ❑ Normal

- ❑ Trouble swallowing
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Red blood in stool
- ❑ Black tarry stool
- ❑ Hemorrhoids
- ❑ Stomach ache

Musculoskeletal ❑ Normal

- ❑ Joint pain
- ❑ Arm/Leg pain
- ❑ Neck pain
- ❑ Back pain

Urinary ❑ Normal

- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Difficulty urination
- ❑ Bloody urine
- ❑ Erectile problem (males)

Neurologic ❑ Normal

- ❑ Numbness/Tingling
- ❑ Loss of bowel or bladder control
- ❑ Dizziness
- ❑ Fainting

Gynecologic ❑ N/A ❑ Normal

- ❑ Pregnant
- ❑ Last menstrual period ___/___/___
- ❑ Abnormal vaginal discharge
- ❑ Abnormal menstrual flow

Other Symptoms: _____

Habits

Tobacco/cigarette

- ❑ I do not smoke, or
- ❑ I smoke _____ Packs/week

Alcohol

- ❑ I do not drink alcohol, or
- ❑ I drink _____ Drinks/week

Drugs

- ❑ I do not use illegal drugs, or
- ❑ I use illegal drugs.

Which ones? _____

_____

Name:

Please print. **Chart #** **Date:**

CITY CARE FAMILY PRACTICE

461 Park Ave South 9th Floor
New York, NY 10016
Phone: (212)545-1888 Fax: (212)545-1919

Chart Number _____
(Office use only)

Attention:

1 We will notify you to let you know how much will be charged to this credit card two days in advance.

2 We **will not be responsible in any way what so ever for fees incured to you** because you do not have sufficient balance/spending limit on this credit card provided.

3 Any outstanding balances will be forwarded to a collection agency in **one month** from the date of the first invoice or call, even though you are on vacation or business trip.

4 If you want to appeal your insurance company's payment decision, please settle your account with us first. We will schedule a credit card reimbursement as soon as we receive the payment from your insurance co.

5 It is your responsibility to update your contact information.

* City Care Family Practice is responsible for the security of cardholders data.

Credit Card Authorization Form

I, _____(Please Print Name) authorize City Care Family Practice P.C. to charge medical fees to my Credit Card.

Name (Please print):		
Phone number: ( ) -	Alternative Phone number: ( ) -	
Billing address for this credit card		
City	**State**	**Zip**
Name as it appears on the credit card (if different than above):		
Card number: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐	Expiration Date:	MM / YY
Select type of card: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover		
CVV2 Number (last 3 or 4 digit number on the back/front of the credit card): ☐☐☐☐		
Signature:	Date:	

Revised 07/01/2019

HIPAA Notice of Privacy Practices

CITY CARE FAMILY PRACTICE, P.C.

461 Park Ave S, 9th Fl, New York, NY 10016 Ph: 212-545-1888 Fax: 212-545-1919

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.

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

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with health care. Some examples of protected health information are:

- Information indication that you are a patient of our practice or receiving treatment or other health-related services from us;
- Information about your health condition (such as a disease you may have);
- Information about health care products or services you have received or may receive in the future (such as an operation or a CT scan); or
- Information about your health care benefits under an insurance plan (such as whether a prescription is covered);

When combined with:

- Demographic information (such as your name, address or insurance status);
- Unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- Other types of information that may identify who you are.

Uses and Disclosures of Protected Health Information

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

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates: We may disclose your health information to our contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. To inspect or obtain a copy of your health information, please submit your request in writing to City Care Family Practice, P.C.. We may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If the restriction interferes with the billing procedure, we would expect a full payment for the services rendered at the time of service. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may ask that we contact you at home instead of at work.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature:_____ Date:_____