Name:

Phone:

email:

Cell:

Date:

Reason for visit: #1 ____________________

Reason for visit: #2 ____________________

In the 2 weeks, have you been bothered by little interest or pleasure in doing things? Yes_____ No _____

In the last 2 weeks, have you been feeling down, depressed, or hopeless? Yes _____ No _____

If you are over 65, have you fallen in the last 12 months? Yes _____ No _____. When walking and standing, do you feel unsteady? Yes ____ No _____:

General

No Yes

[ ] [ ] Change/loss of appetite
[ ] [ ] Chills
[ ] [ ] Fatigue
[ ] [ ] Fever
[ ] [ ] Night sweats
[ ] [ ] Weight gain
[ ] [ ] Weight loss

ENT

No Yes

[ ] [ ] Blocked ear
[ ] [ ] Decreased hearing
[ ] [ ] Decreased smell
[ ] [ ] Dizzy/lightheaded
[ ] [ ] Dry mouth
[ ] [ ] Ear pain
[ ] [ ] Nosebleeds
[ ] [ ] Ringing in ears
[ ] [ ] Runny/congested nose
[ ] [ ] Sinus pain
[ ] [ ] Sore throat
[ ] [ ] Swollen glands
[ ] [ ] Trouble swallowing
[ ] [ ] Vertigo

Cardiovascular

No Yes

[ ] [ ] Chest pain at rest
[ ] [ ] Chest pain with exertion
[ ] [ ] Fainting
[ ] [ ] Irregular heart beat
[ ] [ ] Palpitations
[ ] [ ] Sleeping propped up
[ ] [ ] Swelling of ankles

Allergy/Immunology

No Yes

[ ] [ ] Congestion
[ ] [ ] Hives
[ ] [ ] Itching
[ ] [ ] Sneezing
[ ] [ ] Swollen glands
[ ] [ ] Watery eyes

Endocrine

No Yes

[ ] [ ] Change in voice
[ ] [ ] Cold intolerance
[ ] [ ] Difficulty sleeping
[ ] [ ] Excessive sweating
[ ] [ ] Excessive thirst
[ ] [ ] Excessive urination
[ ] [ ] Heat intolerance

Gastrointestinal

No Yes

[ ] [ ] Abdominal pain
[ ] [ ] Bloody/maroon/black BMs
[ ] [ ] Blood on toilet paper
[ ] [ ] Change in I bowel habits
[ ] [ ] Constipation
[ ] [ ] Diarrhea
[ ] [ ] Exposure to hepatitis
[ ] [ ] Heartburn/indigestion
[ ] [ ] Hemorrhoids
[ ] [ ] Incontinent bowel
[ ] [ ] Nausea
[ ] [ ] Painful swallowing/choking
[ ] [ ] Rectal itching
[ ] [ ] Vomiting

Opthalmology

No Yes

[ ] [ ] Bothered by light
[ ] [ ] Blurry/double vision
[ ] [ ] Dry eyes
[ ] [ ] Eye discharge
[ ] [ ] Floaters in visual field
[ ] [ ] Foreign body in eye
[ ] [ ] Itchy eye
[ ] [ ] Light flashes in vision
[ ] [ ] Painful eye(s)
[ ] [ ] Red eye(s)
[ ] [ ] Vision loss

Respiratory

No Yes

[ ] [ ] Cough
[ ] [ ] Coughing up blood
[ ] [ ] Coughing up sputum
[ ] [ ] Painful breathing
[ ] [ ] Shortness of breath at rest
[ ] [ ] Short of breath on exertion
[ ] [ ] Snoring
[ ] [ ] Wheezing

Hematology/Oncology

No Yes

[ ] [ ] Bleeding gums
[ ] [ ] Excessive bleeding
[ ] [ ] Persistent fevers
[ ] [ ] Previous transfusion
[ ] [ ] Prolonged bleeding
[ ] [ ] Recent, new paleness
[ ] [ ] Swollen glands
[ ] [ ] Unusual bruising

PLEASE ALSO COMPLETE THE OTHER SIDE OF THIS PAGE.

Medical History Update

Date: ______________

Name: ______________________ Age: _____ Occupation: ______________________

Phone: ______________ Mobile: ____________ email: ______________________

Which phone number should we use to leave messages or test results? ______________

With whom may we leave messages or test results? ______________________

Names of household members and relationship: ______________________

______________________ Types of pets, if any: ______________

Religious preference: ____________ Gender Identity: ____________

New Medical History:

Names of any other medical care providers you have seen in the last year: ______________

____

Types of any tests or procedures you have had in the last year: ______________

____

Date of last eye exam? ____________ Date of last dental exam? ____________

Date of latest flu shot? ________ Date of last skin exam (if not done by us): ________

Do you have an advanced directive (Living Will) and/or a Medical Proxy? yes ___ no ___.

Do we have a copy of your Advanced Directive? yes ___ no ___.

Social history

How often do you exercise? [ ]rarely [ ] infrequently [ ] 1-2 times a week [ ] 3-4 times a week [ ] almost daily

Any dietary preferences? ______________ Hobbies? ______________________

Prevention

Do you always wear a seatbelt? yes ___ no ___. Do you wear sunscreen and check your skin for changing moles? yes ___ no ___. Is there a gun in your house? no ___ yes ___

Have you been physically, sexually or emotionally hurt by your partner or other person this year? yes ___ no ___ In the past? no ___ yes ___

Drugs

Have you used drugs other than those required for medical reasons in the last year? No ___ Yes ___.

If not, skip the following questions.

Have you ever injected drugs? No ___ Yes ___. Have you used more than 1 drug at a time? No ___ Yes ___. Are you able to stop using drugs when you want? Yes ___ No ___ Have you ever had blackouts or flashbacks as a result of drug use? No ___ Yes ___. Do you ever feel bad or guilty about your drug use? No ___ Yes ___. Does your partner (or parents) ever complain about your drug use? No___ Yes___. Have you ever had withdrawal symptoms (felt sick) when you stopped taking drugs? No ___ Yes___. Have you ever been in treatment for substance abuse? No___ Yes ___.

Food Security

In the last 12 months, has your family worried that your food would run out before you got money to buy more? Yes ___ No ___ In the last 12 months, did the food your family bought run out before you had money to get more food? Yes___ No ___.

Women only

Frequency of periods? ____________ Length? ______ days. Painful? yes __ no ___ Heavy? yes___ no ___ Abnormal discharge? yes ___ no ___

Using or need contraception? yes ___ no ___ Type? ______________

Do you wish to have your gyn exam today? yes ___ no ___ If not, when was your last exam? _______ By whom? ______________ (Please sign a release to get a copy of your latest Pap for us and any recent mammogram results we don't have. At appointments, please ask that copies of these be sent to us.)

Name: ____________________ Date: __________

Health Risk Assessment

We apologize for adding one more round of paper work. The purpose of this questionnaire is to try to establish a data base that lets us quickly identify patients at risk for problems so that we can hopefully target them for more attention and help. This is a new government requirement for us. We know there are a lot of questions but they should be quick and easy to answer. If you are a parent answering for a child, please answer from the child's point of view.

Patient Section: Circle the correct answer

1. Have you been admitted to a hospital in the last year? (No) (yes) # of times 1 2 3+
2. Have you had to be readmitted to a hospital within 1 month of discharge in the last year? (No) (Yes)
3. Have you gone to an Emergency Room in the last year? (No) (yes) # of times 1 2 3+
4. Have you gone to an Urgent Care facility in the last year? (No) (yes) # of times 1 2 3+
5. Have you stayed in a nursing facility, rehab, transitional care or similar facility in the last year?
6. (No) (Yes) # of times 1 2 3+
7. Do you see other doctors, specialists or providers outside of our office? (No) (yes,1-2) (yes,3) (yes, More than 3)
8. Do you take more than 5 prescription medicines? (No) (5-10 medicines) (Over 10 medicines)
9. Do you have trouble caring for yourself or are you concerned you aren't able to do this as well as in the past? If a child, are your parents having trouble caring for you? (No) (Yes)
10. Do you have health insurance? (No) (Yes)
11. Do you have trouble paying for your medicines? (No) (Yes)
12. Are you or your immediate family having trouble managing financially?(No) (Yes) (OK now but worried about this happening soon)
13. Do you live alone or with other people? (With other people) (Alone) (In a facility with other people nearby to help) (At home with a caregiver (family or paid)
14. Do you have easy access to transportation for necessary trips for food, clothing, medical care, and professional care? If a child, does your family or parent have easy access to transportation for necessary trips for food, clothing, medical care, and professional care? (No) (Yes) (For some things, but not other important ones)
15. Do you need assistance to walk at least some of the time, using crutches, a cane, a walker, or another person? (No) (Yes)
16. Do you need assistance with eating, bathing, dressing, toileting, transferring (walking) or bowel or bladder care? (No) (Yes)
17. Do you think you are at risk for falls due to physical problems? (No) (Yes)
18. Do you use tobacco products? (No) (1Pack/day, or quit <16 yrs ago, > 30 pack year hx, pipes, cigars, vaping) (1 or more packs of cigarettes/day)

Back of page is for office use only.

Authorization to Disclose Protected Health Information

The Health Insurance Portability and Accountability Act (HIPPAA) is a law designed to protect your health information. To be certain that we disclose information about your treatment(S) or medical condition(S) only to those individuals designated by you to receive that information, please complete this form

Patient's Name____

By my signature Below, I authorize the physicians, nurse practitioners and staff of <u>**Lower Merion Family Medicine**</u> to discuss my medical condition(s) and treatment(s) with the following individuals:

Name:________________________ Relationship:______________ Phone #:________________

Name:________________________ Relationship:______________ Phone #:________________

Name:________________________ Relationship:______________ Phone #:________________

Name:________________________ Relationship:______________ Phone #:________________

Name:________________________ Relationship:______________ Phone #:________________

I <u>DO NOT</u> wish to have information released about the Following Conditions:

[ ] AIDS/HIVS [ ]Psychiatric care/conditions [ ]Drug or Alcohol Abuse

This Authorization will be in continuous effect unless I ask for it to be removed or revised

Patient's Signature:____ Date:______________

Patient Registration

Last Name:____________________ First Name:__________________ Middle Initial:______ Date of Birth:____________

Address____________________________________ APT:______________ Sex: Male or Female

City:______________________ STATE:_____________ Zip Code:________________

Home Phone:_____________ Work Phone:______________ Cell Phone:__________________

May we leave a message? Yes or No Where can message be left? Home Work Cell

Email Address:__________________________________ Social Sec#__________________

Marital Status: Single Married Divorced Widowed Spouse's Name:____________________

Race: American Indian Asian African American Native Hawaiian White Other:_____________

Ethnicity: Hispanic/ Latino Not Hispanic/Latino Other:_______________

Preferred Language:______________________________

In case of emergency, Who should we contact?

Name:_______________________ Relationship: Spouse Parent Child Other:_________

Address,City,State:____

Home Phone:________________ work Phone:_________________ Cell Phone:______________

Pharmacy Information:

Local Pharmacy:______________________________________ Phone:________________________

Address,City,State:____

Mail Order Pharmacy:__________________________________ Phone:________________________

Address, City, State:____

Medical Information Release:

I Authorize the Physicians and Staff of Lower Merion Family Medicine to request copies of my medical tests, and treatment results from other health care facilities and providers, including, but not limited to, copies of colonoscopies, mammograms, pap smears, EKGs, operative reports, hospitalizations, X-ray and lab results.

Insurance Authorization and Assignment

I hereby authorize Lower Merion Family Medicine to furnish information to insurance carriers concerning my illness and treatments and I hearby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any deductibles or Co-insurance payments.

Patient or Guardian Signature:____________________________________ Date:_______________________________