INITIAL MEDICAL HISTORY

Name: _____ Date: _____

Age: _____ 1st Day of Last Period: _____ 20 _____

Dr's. Comments: _____

Main Reason for Seeing Dr. Today: _____

_____

Allergies to Medications:

1. _____ 3. _____
2. _____ 4. _____

Current Medications, Including "Over the counter" and Vitamins:
(with dosage and # of times per day)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family History: (Place "X" under the appropriate family member)

	Father	Mother	Fathers Parents	Mothers Parents	Sisters or Brothers	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer (what type)						
Glaucoma						
Diabetes						
Epilepsy						
Bleeding Disorder or Blood Clots						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Depression or Severe Anxiety						
Alcoholism or Drug Abuse						
Gall Bladder Disease						
Other						

Hospitalizations or Surgery: (Include in and outpatient)

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Gynecologic History: (Women Only)

For Dr. G ____ P ____ TAB ____ SAB ____
Complications: _____

Age of 1st Period _____
Interval Between Periods _____ Days (from first day of one to first day of next one)
No, of Pads or Tampons on Heaviest Day _____
Cramps (None, Mild, Moderate, Severe) _____ PMS ____ Yes ____ No ____
Days of Flow _____ Mid-cycle Bleeding or Pain Yes ____ No ____
Current Contraception _____ Satisfied with Method Yes ____ No ____
Previous Forms _____
Yr. Last PAP _____ Result _____
Yr. Last Mammogram _____ Result _____

Past Medical History:

Head and Senses
____Signif.Headaches or Migraine
____Seizures/ Balance Probs.
____Dizziness/ Fainting
____Stroke/ TIA
____Eye/ Ear Problems

Nose/Sinuses/Lungs
____Allergies/Hay fever
____Sinus Infections
____Asthma/Emphysema
____Tuberculosis or (+) TB Test
____Chronic Bronchitis
____Shortness of Breath
____Other Lung Problems

Heart and Blood Vessels
____Heart Attack, Bypass Surgery or Angioplasty
____Hypertension/ Hi BP
____Elevated Cholesterol
____Chest Pain/ Angina
____Swelling in legs
____Blocked Arteries (Legs)
____Varicose Veins with Symptoms
____Palpitations/ Irreg. Pulse

Hormones
____Diabetes
____Pain with sex, Inability to complete sex
____Menopausal symptoms
____Thyroid problems
____Breast Probs.

Urinary Problems
____Kidney or bladder probs.
____Venereal Disease Hist.
____Other inc. Prostate probs.

Digestion
____Frequent Indigestion/GERD
____Ulcers, Gall bladder Disease
____Frequent Diarrhea/ Constip.
____Change in Usual BM
____Abd. Cramping or pain, freq.
____Blood in vomit or stool

Nervous System/Emotions
____Numbness, weakness
____Coordination difficulty
____Depression/Anxiety
____Alcohol or Drug abuse
____Other Mental disorder

Joints/Bones
____Arthritis/ Joint pain
____Osteoporosis, osteopenia
____Gout/Back or neck pain

Blood
____History Blood Clots or Easy Bleeding
____Anemia

Other ___ Skin Disease of any type
___Cancer of any type
___Chronic Fatigue
___Enlarged lymph glands
___Other_____

Date of: (Give approx, date, if not sure)
Last Chest X-Ray _____ Last Electrocardiogram _____ Last Tetanus Shot _____
Pneumonia Vaccine _____ Sigmoidoscopy _____ Colonoscopy _____

Social History:

Current Smoker Y____ N ____ • # Packs/ Daily? ____ • For How Long? ____ • When Stopped? ____
Coffee or Other Caffeine: # of Cups/ Daily? ____
Trouble Falling Asleep Regularly? Y ____ N ____
Trouble Staying Asleep More Than Rarely? Y ____ N ____
Awake Refreshed? Y ____ N ____
Participate in an Exercise Routine? Y ____ N ____
Current or Past Recreational Drug Use? Y ____ N ____
Alcohol: Number of Drinks/ Weekly? ____ • Diet: Number of Meals Per Day? ____ Is your diet healthy? Y ____ N ____
Always wear seatbelts in car? Y ____ N ____
Highest level of school completed? _____
Current Occupation/Past Occupations? _____
Satisfied with current work? Y ____ N ____
Number of years in San Diego? _____ • Raised where? _____
In current relationship for _____ years. Rewarding? Y ____ N ____
I have Sexual Concerns? Y ____ N ____
Health of partner? _____ • Sexually Active? Y ____ N ____
I live with _____ - (Husband/Wife, partner, boyfriend/girlfriend, roommate, children, alone)

Current stresses: _____
_____
_____

Janet Schwartz, M.D.
9834 Genesee Avenue, Suite # 320
La Jolla, CA 92037

CANCELLATION POLICY

We strive to give each one of our patients the very best service possible. We value your patronage and look forward to a long and rewarding relationship.

It is in this spirit that we would like to inform you of our policy concerning missed appointments.

To discourage NO-SHOW and SAME DAY cancellations, we must require that 24-hours notice be given to cancel or reschedule appointments. If 24-hours notice is not given, for routine appointments there will be a fee of $25.00. For MISSED, NO-SHOW, SAME DAY CANCELLATIONS, or SAME DAY RESCHEDULING for annuals, physicals, or surgical procedures, there will be a fee of $100.00.

We regret the need for this policy and sincerely hope you will not be affected by it.

PRESCRIPTION REFILLS

For your convenience, please allow our office 48 hours advance notice noticed for any prescription refills. Contact your pharmacy and have them fax a request to our office whether you have more refills left or not.
PLEASE MAKE ARRANGEMENTS FOR REFILLS WHEN THERE IS AT LEAST A WEEK LEFT OF YOUR MEDICATION.
FAX: (858) 457-1565

_____ _____

Signature Date

Janet R. Schwartz, M.D.
Authorization to Release Health Information

_____ _____
Patient Name Date of birth

Send Records to: **Dr. Janet Schwartz, MD**
9834 Genesee Suite, #320
La Jolla, CA 92037
Phone: **858-457-5555**
Fax: **858-457-1565**

I authorize _____, to release my medical records as requested below.

For Healthcare Covering the Period(s) [ ] From: _____To: _____

Complete Health Record to be disclosed or (check appropriate boxes):
[ ] History & Physical Exam [ ] All records [ ] Discharge Summary
[ ] X-Rays & Ultrasounds [ ] Laboratory Tests [ ] Consultations
[ ] Consent for **Dr. Schwartz** or staff to speak w/another provider:

_____

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health or Sexually Transmitted Diseases.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries wit the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Unless otherwise indicated, this authorization will expire 1 year from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at anytime, expect to the extent that the action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may be a fee for preparing and furnishing thus information, for which I am responsible.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

PATIENT RIGHTS

1)RIGHT TO FILE A COMPLAINT: IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED, YOU CAN FILE A COMPLAINT WITH OUR PRACTICE OR DR. SCHWARTZ. ALL COMPLAINTS MUST BE SUBMITTED IN WRITING. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

2)RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES: OUR PRACTICE WILL OBTAIN YOUR WRITTEN AUTHORIZATION FOR USES AND DISCLOSURES THAT ARE NOT INDENTIFIED BY THIS NOTICE OR PERMITTED BY APPLICABLE LAW.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY POLICIES, PLEASE ADVISE SOME ONE IN OUR PRACTICE.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF Janet Schwartz, MD A.P.C NOTICE OF PRIVACY PRACTICES.

SIGNATURE:_____

DATE:_____

NAME OF PATIENT:_____

EMPLOYEE INITIALS:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

Janet R. Schwartz, M.D., APC

9834 Genesee Avenue, Suite 320
La Jolla, CA 92037

PATIENT INFORMATION

(Please Read & Complete all sections below, please print your entry)

PATIENT NAME & HOME ADDRESS

Last Name: _____
First Name: _____
Middle Initial: _____
Birth Date: _____
Sex (circle one): M F
Martial Status (circle one): S M D W
Spouse Name (if applicable): _____

Home Address: _____
City, State, Zip : _____
Home Phone #: _____
Driver's Lic.: State: _____ #: _____
Social Security #: _____
Spouse Work Phone #: _____

EMPLOYMENT DATA

Occupation: _____
Employer: _____

Employer Address : _____
Address (continued): _____
Work Phone #: _____

RESPONSIBLE PARTY (Financial Guarantor for Services)

Last Name: _____
First Name: _____
Birth Date: _____
Relationship to Patient: _____
Social Security #: _____
Occupation: _____
Driver's Lic.: State: ____ #: _____

Home Address: _____
Address (continued): _____
Home Phone #: _____
Employer: _____
Employer Address : _____
Address (continued): _____
Work Phone #: _____

HEALTH INSURANCE INFORMATION

Primary Insurer: _____
Policy #: _____
Group #: _____

Secondary Insurer: _____
Policy #: _____
Group #: _____

EMERGENCY CONTACT

Last Name: _____
First Name: _____

Address: _____
Address (continued): _____
Phone #: _____

PHARMACY INFORMATION

Pharmacy Name: _____
Pharmacy Phone #: _____
Address: _____
Address (continued): _____

Ins. Co. Contracted Laboratory Name: _____
Phone number: _____
Address: _____
Address (continued): _____

Thank you for providing this information. Please read the following and sign below.

I hereby give authorization for payment of insurance benefits to be made directly to Janet R. Schwartz, MD for services rendered. I am financially responsible for all charges not covered by insurance. In the event of default, I agree to pay all costs of collection, and attorney fees. I authorize Janet R. Schwartz, MD to release all information necessary to secure payment of benefits. This authorization is valid for a period of one year.

Signature: _____ Date: _____

☐ *(FOR OFFICE USE ONLY: RECORDED IN COMPUMEDIC)*