

# NALLY FAMILY PRACTICE

## Welcome. Why choose Nally Family Practice?

We would like to be your nearby Surprise, Arizona, family physician office. Our office is made up of three practitioners, Dr. Adam Nally and physician assistants, Brad Hall PA-C, and Brant Morrow PA-C. They work closely together to provide the best care for you and your family.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- set up appointments
- view your personal health record
- examine your current and past statements

You must fill out all of the enclosed forms completely prior to your first appointment. Incomplete paperwork will affect your visit with the doctor. As a patient of our practice it will be **required** for you to provide your SSN for identification purposes and prescriptions, please talk to our office staff with any questions or concerns. Please check that you have received, filled out, and signed these forms included in this packet:

- |  |   |
|--|---|
| <input type="checkbox"/> Demographics form ..... page 1    | <input type="checkbox"/> ERISA Authorization ..... page 4               |
| <input type="checkbox"/> Insurance form ..... page 2       | <input type="checkbox"/> ABN (Advanced Beneficiary Notice) ..... page 4 |
| <input type="checkbox"/> Disclosure of health ..... page 3 | <input type="checkbox"/> Explanation of Physical ..... page 5           |
| <input type="checkbox"/> Email Authorization ..... page 3  | <input type="checkbox"/> Health History assessment ..... pages 6-8      |

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_

## Demographics

Please Complete prior to your first office visit, so we can better assist you with your health during that visit.  
Please print all written information.

### Patient Information

First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ Suffix: \_\_\_\_\_ Sex: Female Male

Preferred name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: Married Divorced Single Widowed Primary Language: English Spanish Other: \_\_\_\_\_

Ethnicity: Caucasian Black Hispanic Asian Other: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Telephone: \_\_\_\_\_ Leave VM? Yes No Secondary Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Pharmacy (name & cross streets) \_\_\_\_\_

E-mail: \_\_\_\_\_

*\*E-mail authorization is a separate form that specifies what we can send you, for example; electronic statements, forms to update your chart, and login information about your portal account.*

### Family Information

Spouse's name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Leave VM? Yes No

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

Number of Child 1: \_\_\_\_\_ Child 2: \_\_\_\_\_ Child 3: \_\_\_\_\_

children: \_\_\_\_\_ Child 4: \_\_\_\_\_ Child 5: \_\_\_\_\_ Child 6: \_\_\_\_\_

Other children: \_\_\_\_\_

Are your children covered under your insurance Policy? Yes No Spouse's? Yes No

### Emergency Contacts

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

## Insurance information

Please Complete prior to your first office visit, so we can better assist you with your health during that visit.

*\*Please make sure to inform the office whenever any of your insurances change.*

### Primary Insurance

Insurance Name: \_\_\_\_\_ Effective Date start: \_\_\_\_\_ End: \_\_\_\_\_  
 ID-Policy-Subscriber Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insurance Address to submit Claims: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy Holder's Full Name: \_\_\_\_\_ \*Same as on insurance Card\*  
 Policy Holder's SSN: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_  
 Relationship to patient: Self Other: \_\_\_\_\_  
 Employer of Policy Holder: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Secondary Insurance

Insurance Name: \_\_\_\_\_ Effective Date start: \_\_\_\_\_ End: \_\_\_\_\_  
 ID-Policy-Subscriber Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insurance Address to submit Claims: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy Holder's Full Name: \_\_\_\_\_ \*Same as on insurance Card\*  
 Policy Holder's SSN: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_  
 Relationship to patient: Self Other: \_\_\_\_\_  
 Employer of Policy Holder: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Tertiary Insurance

Insurance Name: \_\_\_\_\_ Effective Date start: \_\_\_\_\_ End: \_\_\_\_\_  
 ID-Policy-Subscriber Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insurance Address to submit Claims: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy Holder's Full Name: \_\_\_\_\_ \*Same as on insurance Card\*  
 Policy Holder's SSN: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_  
 Relationship to patient: Self Other: \_\_\_\_\_  
 Employer of Policy Holder: \_\_\_\_\_ Telephone: \_\_\_\_\_

***(The above information must be filled out completely or patient will be considered a cash pay and be billed for services rendered)***

I \_\_\_\_\_ hereby authorize Adam S. Nally, DO. Office to release any information acquired in the course of my examination or treatment to the referring physician or insurance carriers listed above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

## Disclosure of Health Information to Family, Friends or Others

The HIPAA Privacy Rule prohibits the disclosure of Protected Health Information (PHI) without the authorization of the patient. Examples of PHI would be test results, medication information, payment information, or anything considered patient condition, treatment, or payment related. Please choose one of the following disclosure options:

- No, do not** allow disclosure of my PHI to anyone, including family members, other relatives, close personal friends, etc.
- Yes, please allow** disclosure of my PHI (including detailed messages by phone, fax, e-mail, voice mail, or any other means) to my contact info and to the following person(s):

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, to my personal contact information or with the above-named persons. I understand that it is my responsibility to keep the office informed of any changes to this information and agree to hold the office harmless if my PHI is disclosed due to my failure to notify the office of changes or updates.**

### E-mail Authorization

Our office now has a notification program for our patients who have e-mail. If interested, you would receive notification on your laboratory, radiological or other diagnostic data via e-mail instead of by phone.

This program will be for normal studies only. If your diagnostic data is normal, you will receive an e-mail including a copy in "PDF" format of your study as an attachment to your e-mail. Any abnormal labs will not be e-mailed and you will be notified via the phone regarding instructions that Dr. Nally would like you to follow.

Our office also offers an E-statement option. You have the choice of receiving your billing statements via e-mail, or regular mail. It is a secure 256 bit encryption and SSL protected way to receive your statements.

By checking yes and signing this form, you are giving Nally Family Practice (Adam S. Nally, D.O., P.C.) permission to send diagnostic studies and E-statements for your review to the e-mail address below. It is your responsibility to ensure that the address below is secure and protected. It is also your responsibility to immediately notify our office when changes to your e-mail address occur. It is our intent to help you receive information about your medical care in a more efficient manner.

#### Electronic Diagnostic Results

- Yes – I would like to receive my results via e-mail
- No – I do not want my results via e-mail

#### Electronic Billing Statements

- Yes – I would like to receive e-statements.
- No – I do not want my billing statements via e-mail

#### Electronic Forms

- Yes – I would like to receive my annual update forms via e-mail
- No – I do not want my forms via e-mail

Patient Full Name: \_\_\_\_\_

E-mail Address (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We do not create individual profiles with the information you provide. If information is collected, it will be used solely in connection with Nally Family Practice. We do not give, sell, or transfer any personal information to a third party. All information is securely stored with 256-bit encryption and SSL protection.

# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_

## ERISA Authorization

For good and valuable consideration, I \_\_\_\_\_, do hereby designate, authorize, and convey to Dr. Adam S. Nally, D.O. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan:

- a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee Health care benefit plan; and
- b) The right and ability to act on my behalf to pursue such claim, right or chose in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or other health care expense incurred as a result of the service I received from the above-named doctor and, to the extent permissible under law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize the office of Adam S. Nally, D.O. to obtain, on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) files. I further agree to pay all collection on costs, attorney fees, and any other collection costs that may be incurred to enforce collections of any amounts outstanding, including a \$45 fee for any account sent to collections or for any returned checks per the office financial policy. A copy of the office financial policy is available upon request. I authorize payment of medical benefits to the provider for services of these insurance companies listed on Insurance Information form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ADVANCED BENEFICIARY NOTICE (ABN) – \_\_\_\_\_

This notice is to inform you that periodically your doctor may order testing or perform an examination that is not a covered item or service under your insurance plan. Your insurance only pays for covered items and services when certain rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There are legitimate reasons your doctor may recommend particular items or services that are not covered. It is ultimately your responsibility, as the insured, to know what your individual insurance plan will and will not cover. By signing this form, you are agreeing to pay for services rendered that are not covered by your insurance company. The most common items or services not covered but frequently recommended by your doctor are:

### For Medicare Advantage plans and For Commercial Payers

- Complete yearly physical (99397)
- Annual Wellness Visit (AWV) initial G0438 and subsequent G0439 is a covered Medicare Benefit; *an AWV is not a complete or partial physical.*
- Pap smear collection (Q0091)/Breast/pelvic exam (G0101) is paid 100% during complete yearly physical
- Preventative or Screening ekg (93000) is not a covered benefit
- Hepatitis A injection (90632 – 90634)
- TDaP – (90715), Tetanus vaccine (90703), B12 injection (J3420)
- Dietary counseling for BMI 29 and lower

Any patient requesting to schedule a preventive service such as a physical that wishes to discuss any other health problems with the doctor needs to ask their insurance carrier if they bundle a problem-oriented visit with preventive service. It is our recommendation to schedule the problem-oriented visit first and the preventive service another day. If two different appointments is an inconvenience and lost work time for a patient they are encouraged to contact their insurance company and his or her employer and state that the consequences of the insurer's payment policy is an inconvenience. It takes many voices to make a change for the better.

By signing this form, I understand that my insurance may not cover the above items or services and that I may have to pay the bill while my insurance makes its decision. If my insurance does pay, I will be refunded any payment that is due to me. If my insurance denies payment, I agree to personal and full responsibility for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance's decision.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_

## Explanation of Physical Exam versus Problem Focused Visit

Terms you should know when scheduling your appointment:

- Physical (Complete physical)
- IPPE (Welcome to Medicare physical)
- AWV (Annual wellness visit) for those 65 and older

We want you to receive wellness care – health care that may lower your risk of illness or injury. Most commercial plans cover wellness care. For those that qualify for Medicare or Medicare advantage insurance plans, it is important to note that you plan pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medical benefits and how we can help you get the most from them.

The term “physical” is often used to describe wellness care. But Medicare and Medicare advantage plans does not pay for a traditional, head-to-toe physical. Some secondary and tertiary payers will cover the cost of your “physical” it is important for you to contact your insurance providers and know your coverage benefits prior to your visit. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment and during, our staff will ask you some questions about your health and may ask you to fill out a form. A physical, IPPE, and AWV **DOES NOT** include addressing specific new or existing health problems or refilling medication. That would be a separate service and may require a longer appointment.

Please let our scheduling staff know if you need the doctor's help with a health problem, a refill or something else. A separate charge applies to these services, whether provided on the same date or a different date than the physical, IPPE, or AWV.

We hope to help you get the most from your wellness benefits. Please contact us with any questions.

Sincerely,

Nally Family Practice

## Office Financial Policy

- ✓ Any outstanding balance of \$30 or more will go to pre-collections 30 days after the due date on the statement. If an account is sent to pre-collections, a fee of up to \$20 will be applied.
- ✓ Any patient account that goes to final collections will be subject to a \$45 fee.
- ✓ Any declined financial transaction (returned check, rejected electronic draft, etc.) will be subject to a \$45 fee.
- ✓ Patient accounts that are sent to final collections or file bankruptcy will be discharged from our practice.
- ✓ Patients with large outstanding balances may need to make payment arrangements or pay in full before being seen. Seeing patients with large outstanding balances is at the discretion of the medical provider.
- ✓ Copays are the responsibility of the patient. Any questions about copays should be directed to the patient's insurance company.
- ✓ Patients with large deductible plans, no insurance (self-pay), or out-of-network plans will be required to pay at time of service.

I acknowledge my understanding and acceptance of this policy and agree to abide by all terms of this office financial policy.

Name \_\_\_\_\_ Date \_\_\_\_\_

***This financial policy is available to all patients by request.***

February 7, 2018



# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_

## Health History

*Please Check those conditions you have been diagnosed with and write any that are not listed below.*

**Vision:**       Cataracts                       Glaucoma                       Macular Degeneration

**Hearing:**       Hearing loss                       Dizziness                       Vertigo  
                     Tinnitus (ringing in ears)

**Allergies :** (Environmental)       Chronic (sinus infection)                       Allergic rhinitis (runny nose)

**Lungs:**       Asthma                       Emphysema                       Valley fever                       COPD  
                     Pulmonary Embolism

**Cardiovascular:**       Hypertension (Elevated blood Pressure)                       Dyslipidemia (High cholesterol)  
                     Myocardial Infarction (Heart Attack)                       Dysrhythmia (Abnormal heart rhythm)  
                     Atrial fibrillation                       Heart murmur  
                     CHF (heart Failure)                       CAD (heart disease)

**Vascular Disease:**       Use of Anti-Coagulant (Blood thinner daily)       DVT (blood clot in extremity)  
                     Hemophilia (bleeding Disorder)                       Coagulopathy (clotting disorder)  
                     CVA (Stroke)                       TIA (mini-stroke)                       Peripheral Vascular Disease (PVD)

**Endocrine:**       Hashimoto's disease       Graves' disease                       Anemia                       Thyroid cancer  
                     Hyperthyroidism                       Hypothyroidism                       CKD (chronic kidney Disease)  
                     Iron deficiency                       Vitamin D deficiency                       Vitamin B12 deficiency  
                     Diabetes Mellitus (DM) Type I (insulin use)       Diabetes Mellitus (DM) Type II

**Cancer:**       Previous Type:                       Current Type:

**Neurologic:**       Encephalopathy:                       Neuropathy:  
                     Concussion/head trauma (date):                       Sciatica Location:  
                     Parkinson's disease       Tremor                       Alzheimer's disease       Neuritis  
                     Seizure disorder                     

**Rheumatologic:**       Rheumatoid arthritis       Osteopenia                       Herniated Disk                       Lupus  
                     Fibromyalgia                       Osteoporosis                       Chronic Fatigue syndrome  
                     Connective tissue disorder  
                     Osteoarthritis:       Spine       Hips       Knees       Ankles/Feet       Shoulders       Hands  
                     Chronic back problems:       Neck       Mid-Back       Low-Back

**Gastrointestinal**       Hemorrhoids                       Hiatal hernia                       Diverticulosis  
                     GERD (acid reflux)                       Diverticulitis                       PUD (Peptic Ulcer Disease)  
                     Cholecystitis (Gallstones/Gall bladder)  
                     Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis)

**Genitourinary:**       Overactive bladder                       Kidney stones                       Recurrent UTI  
                     Incontinence:       Stress or       Urge                       Chronic Hematuria (blood in urine)  
                     Sexually Transmitted Disease (STD):       Herpes                       Gonorrhea       Trichomonas       HPV

Male:       Erectile dysfunction       Prostate Cancer                       BPH (prostate enlargement)

Female:       Uterine fibroid                       Ovarian Cysts                       Abnormal menses  
                     Fibrocystic breast disease

**Skin:**       Psoriasis                       Eczema                       Fungal skin infection  
                     Actinic Keratosis (pre-cancers)

**Psychiatric:**       Depression                       Anxiety                       Mood disorder                       Alcoholism  
                     Drug abuse

**Previous Fractures:** \_\_\_\_\_

**Other:** \_\_\_\_\_



# NALLY FAMILY PRACTICE

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_

**Health History: Surgical History**  
*Please check all that apply and year done (approximate) and write in any that are not listed below.*

<b>ENT:</b>	<input type="checkbox"/> Cataract	<input type="checkbox"/> Retina	<input type="checkbox"/> Sinus surgery	<input type="checkbox"/> Tonsillectomy
<b>GI:</b>	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Bowel surgery	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Laparoscopy
	<input type="checkbox"/> Cholecystectomy (Gall bladder)		<input type="checkbox"/> Hernia Repair: <input type="checkbox"/> L <input type="checkbox"/> R (location):	
<b>Cardio:</b>	<input type="checkbox"/> CABG (heart bypass)	<input type="checkbox"/> Heart transplant	<input type="checkbox"/> PTCA (Cardiac Stent)	<input type="checkbox"/> Valve replacement
	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Cardiac Ablation		
<b>GU:</b>	<input type="checkbox"/> C-section#: _____	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Bladder surgery	
	L R		L R	
<b>Extremities:</b>	<input type="checkbox"/> <input type="checkbox"/> TKA (Total Knee Replacement)		<input type="checkbox"/> <input type="checkbox"/> THA (Total Hip Replacement)	
	<input type="checkbox"/> <input type="checkbox"/> Shoulder Surgery		<input type="checkbox"/> <input type="checkbox"/> Joint Arthroscopy (location):	
<b>Pregnancy/ Menstrual History:</b>	#Pregnancies: _____	#Birth(s): _____	#Still birth(s): _____	#Miscarriage(s): _____
	#Elective abortion(s): _____		Abnormal PAP History: <input type="checkbox"/> yes <input type="checkbox"/> no	
	Menstruation regularity: <input type="checkbox"/> Monthly <input type="checkbox"/> Irregular <input type="checkbox"/> Menopausal		Date of last PAP: _____	
	Date of last menstrual period: _____		Date of last DEXA (bone density) Scan: _____	
	Date of last Mammogram: _____		Date of last DEXA (bone density) Scan: _____	
<b>Other screening exams:</b>	(year) EKG: _____	EGD: _____	Chest X-ray (CXR): _____	Colonoscopy: _____

**Health History: Drug allergies/ intolerances**  
*Please list all medications that you have had an allergy to or side effects from plus the type of reaction.*

**Medications/vitamins/supplements** *Please list all medications including herbal products and supplements.*

Medication & Strength	i.e. Lisinopril 10mg	Dosing	i.e. 1 tablet/capsule	Frequency	i.e. once a day

**IMMUNIZATIONS** *Please give the last date of the immunizations below.*

Hepatitis A: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ Pneumonia: \_\_\_\_\_ Typhoid: \_\_\_\_\_  
 Yellow Fever: \_\_\_\_\_ Small Pox: \_\_\_\_\_ Tetanus: \_\_\_\_\_ Influenza: \_\_\_\_\_  
 TB Skin Test:  Positive  Negative

**Health History: Family History**  
*Please check for which side (Maternal, Paternal) all those that apply and write in any that are not listed.*

	YOUR father:		YOUR mother:	
	M	P	M	P
<b>Cardiovascular</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lungs:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular disease:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_

**Health History: Family History continued**

Please check for which side (Maternal, Paternal) all those that apply and write in any that are not listed.

	MP	M P
<b>Neurologic:</b>	<input type="checkbox"/> Encephalopathy: _____ <input type="checkbox"/> Sciatica Location: _____ <input type="checkbox"/> Neuropathy: _____ <input type="checkbox"/> Neuritis: _____	<input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Tremor <input type="checkbox"/> Parkinson's disease
<b>Endocrine:</b>	<input type="checkbox"/> Hashimoto's Disease <input type="checkbox"/> Thyroid cancer <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> CKD (chronic kidney Disease) <input type="checkbox"/> Iron deficiency <input type="checkbox"/> Diabetes Mellitus(DM); <u>Type I</u> (insulin use)	<input type="checkbox"/> Graves' disease <input type="checkbox"/> Anemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Vitamin B12 deficiency <input type="checkbox"/> Vitamin D deficiency <input type="checkbox"/> Diabetes Mellitus(DM); <u>Type II</u>
<b>Gastrointestinal</b>	<input type="checkbox"/> GERD (acid reflux) <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis)	<input type="checkbox"/> Cholecystitis (Gallstones/Gall bladder) <input type="checkbox"/> PUD (Peptic Ulcer Disease)
<b>Rheumatologic</b>	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Herniated Disk <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Connective tissue disorder	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Chronic Fatigue syndrome <input type="checkbox"/> Other: _____
<b>Psychiatric:</b>	<input type="checkbox"/> Depression <input type="checkbox"/> Drug abuse	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety Mood disorder
<b>Cancer:</b>	<input type="checkbox"/> Colon <input type="checkbox"/> Prostate <input type="checkbox"/> Leukemia <input type="checkbox"/> Gastric	<input type="checkbox"/> Pancreatic <input type="checkbox"/> Bone <input type="checkbox"/> Lung <input type="checkbox"/> Other: _____

YOUR Siblings: \_\_\_\_\_ Paternal family: \_\_\_\_\_ Maternal Family: \_\_\_\_\_

**Health History: Social history**

*Circle or check all those that apply.*

Marital Status:  Single  Married  Divorced  Remarried  Widowed  
 Who do you live with? \_\_\_\_\_ Number of Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Religious Preference: \_\_\_\_\_  
 Sexual Activity:  Inactive  Active-Single Partner  Active-Multiple partners  Active-Same gender partner  
 Tobacco Use:  Never  Quit (year \_\_\_)  Current: ( Cigarette  Cigar  Chew) Packs per day: \_\_\_ for \_\_\_ years  
 Alcohol Use:  None  Number of beers/ glasses of wine # \_\_\_, per day / week/ month: \_\_\_\_\_  
 Illicit Drug Use:  Never  Quit  Current: ( Marijuana  Methamphetamines  Cocaine  Heroin  Ecstasy)

**Advanced directives**

*If you have any of the below documents, please bring a copy in for your medical record.*

Do you have an Advanced Medical Directive?  Yes  No Do you have a Living Will?  Yes  No  
 Do you have a medical Power of Attorney?  Yes  No  
 What are we seeing you for today? \_\_\_\_\_  
 What are your main symptoms? \_\_\_\_\_  
 Please list any other concerns: \_\_\_\_\_  
 How did you find us? \_\_\_\_\_

Thank you and Welcome to the practice.