PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT **Date: _____**

PATIENT'S NAME: _____ SSN#: _____ DOB: _____ SEX: _____

PATIENT'S STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOME PHONE#:_____ CELL PHONE#: _____

EMPLOYER: _____ EMPLOYER PHONE# _____

EMAIL ADDRESS: _____

NEAREST RELATIVE/KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE#:_____ WORK PHONE#: _____

DATE OF LAST PHYSICAL EXAM: _____ PHYSICIAN: _____

MEDICAL EQUIPMENT: Do you use a Cane ___ Oxygen ___ Catheter ___ Wheelchair ___ Nebulizer ___
Do you use Glasses? ___ Hearing Aid ___

SOCIAL HISTORY: Alcohol ___ Smoking ___ Drugs ___ Other _____ **RELIGION**: _____

ETHNICITY: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to Disclose

RACE: (Please check below)

□ American Indian or Alaska Native □ Asian □ Black or African □ White
□ Native Hawaiian or Other Pacific Islander □ Hispanic □ Other Race □ Prefer not to Disclose

MARITAL STATUS: Married ___ Widowed ___ Single ___ Divorced ___ Separated ___ Live Alone ___

IMMUNIZATIONS: Pneumococcal ___ Rubella ___ Tetanus ___ Influenza ___ Diphtheria ___ Other _____

FAMILY HISTORY:

	Alive	Dead	Age	Cause of Death
Mother				
Father				
Brother				
Sister				

Check if you have/had any of the following illnesses. If unsure, leave blank:

	Self	No	Relative		Self	No	Relative		Self	No	Relative
Alcohol Overuse	□	□	□	Epilepsy	□	□	□	Mumps	□	□	□
Allergies (other than medications)	□	□	□	Frequent Kidney/Bladder Infections	□	□	□	Nervous Breakdown	□	□	□
Anemia	□	□	□	Frequent Lung Infections	□	□	□	Radiation Treatments	□	□	□
Arthritis	□	□	□	Gallbladder Disease	□	□	□	Rheumatic Fever	□	□	□
Asthma	□	□	□	Goiter	□	□	□	Sexually Transmitted Diseases	□	□	□
Bleeding Tendency	□	□	□	Gout	□	□	□	Sickle Cell Anemia	□	□	□
Cancer	□	□	□	Hay Fever	□	□	□	Stomach Ulcers	□	□	□
Chicken Pox	□	□	□	Heart Attack	□	□	□	Stroke	□	□	□
Colitis	□	□	□	Hepatitis	□	□	□	Suicide Attempt	□	□	□
Congenital Heart Disease	□	□	□	High Blood Pressure	□	□	□	Thyroid	□	□	□
Depression	□	□	□	Intestinal Polyps	□	□	□	Tuberculosis	□	□	□
Diabetes	□	□	□	Jaundice	□	□	□	Whooping Cough	□	□	□
Dialysis	□	□	□	Leukemia	□	□	□	Other	□	□	□
Emphysema	□	□	□	Measles	□	□	□				
				Migraine	□	□	□				

PATIENT NAME: _____ DATE: _____

OPERATIONS: List and indicate approximate year.

_____

_____

_____

SERIOUS INJURIES: (Other than the above) List injuries and give approximate dates

_____

_____

_____

HOSPITALIZATIONS: (Other than operations, **especially in the last year**)

_____

_____

_____

_____

MEDICATIONS: - INDICATE IF YOU TAKE ANY OFTHE FOLLOWING ADMINISTRATION.

	MEDICATION NAME	**DOSAGE**	**FREQUENCY**
	INDICATE THE DOSE AND FREQUENCY OF DRUGS		
□ ASTHMA WHEEZING MEDICINE	_____	_____	_____
□ ASPIRIN, BUFFERIN, ANACIN, TYLENOL OR SIMILAR PRODUCTS	_____	_____	_____
□ BLOOD PRESSURE PILLS	_____	_____	_____
□ CORTISONE, PREDNISONE	_____	_____	_____
□ COUGH MEDICINE	_____	_____	_____
□ DIGITALIS OR HEART MEDICINE	_____	_____	_____
□ HORMONES	_____	_____	_____
□ INSULIN OR DIABETIC PILLS	_____	_____	_____
□ ANEMIA MEDICINE	_____	_____	_____
□ LAXATIVES	_____	_____	_____
□ MOTRIN, ADVIL	_____	_____	_____
□ SLEEPING PILLS/TRANQUILIZERS	_____	_____	_____
□ THYROID MEDICINE	_____	_____	_____
□ STOMACH/DIGESTIVE MEDCINE	_____	_____	_____
□ WEIGHT-REDUCING PILLS	_____	_____	
_____			
□ DILANTIN	_____	_____	_____
□ WATER PILLS, DIURETICS	_____	_____	_____
□ ANTIBIOTICS	_____	_____	_____
□ PHENOBARBITAL/BARBITUATES	_____	_____	_____
□ VITAMINS	_____	_____	_____
□ OTHER PRESCRIPTION OR OVER THE COUNTER DRUGS	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES □ NO □

IF YES, PLEASE LIST MEDICATIONS AND THE REACTION YOU HAD WITH THEM.

_____

_____

_____

_____

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS: Please circle **"Y"** for **YES** to the following question **ONLY** if the problem is of significant concern in the recent past (1 month) or unless the question specifically states "**EVER**."

1. GENERAL:

Do you usually feel persistently tired or worn out?	**Y**	**N**
Have you recently been drinking more waters or fluids?	**Y**	**N**
Has there been any unusual weight gain or loss recently?	**Y**	**N**

2. CARDIOVASCULAR:

Do you have pain, tightness or pressure in the front or back of your chest?	**Y**	**N**
Have you been told your electrocardiogram was abnormal?	**Y**	**N**
Do you have any swelling of your feet or ankles?	**Y**	**N**
Does your heart ever beat fast or irregularly?	**Y**	**N**
Do you have cramps in the calf muscles when you walk?	**Y**	**N**
Do your fingers or toes ever get cold, become numb and get very white or bluish?	**Y**	**N**

3. CENTRAL NERVOUS SYSTEM:

Do you have frequent or severe headaches?	**Y**	**N**
Do you often have spells of dizziness, faintness or lightheadedness?	**Y**	**N**
Do you sometimes lose the ability to speak?	**Y**	**N**
Have you recently fainted, blacked out, lost consciousness?	**Y**	**N**
Do you have trouble remembering recent events?	**Y**	**N**
Do you ever have convulsions or fits?	**Y**	**N**
Have you ever wanted to commit suicide?	**Y**	**N**
Do you ever hear voices or see people when no one is around?	**Y**	**N**

4. EYES:

Have you had:		
Any pain in your eyes?	**Y**	**N**
Glaucoma?	**Y**	**N**
Blurry vision?	**Y**	**N**
Halo around lights?	**Y**	**N**
Change in vision?	**Y**	**N**
Cataracts or implants?	**Y**	**N**
Do you wear glasses?	**Y**	**N**

When did you last see an eye doctor? _____

5: ENT:

Do you have any trouble hearing?	**Y**	**N**
Do you have ringing or buzzing in your ears?	**Y**	**N**
Do you have earaches or discharge from your ears?	**Y**	**N**
Do you have drainage down the back of your throat?	**Y**	**N**
Do you have frequent or severe nose bleeds?	**Y**	**N**
Do you have persistent hoarseness?	**Y**	**N**
Do you have bleeding gums?	**Y**	**N**
Do you use a hearing aid?	**Y**	**N**

6. GASTROINTESTINAL:

Have you recently had any change in your eating habits?	**Y**	**N**
Have you recently noted any trouble in swallowing?	**Y**	**N**
Do you have a lot of indigestion or heartburn?	**Y**	**N**
Have you ever vomited blood?	**Y**	**N**
Are you bothered with constipation?	**Y**	**N**
Do you have frequent loose stools or diarrhea?	**Y**	**N**

7. SKIN:

Do you have any changes in the color of your skin?	**Y**	**N**
Do you have any rashes or itching?	**Y**	**N**
Do you have any growths or lumps on your skin?	**Y**	**N**
Do you have any sores or wounds that do not heal?	**Y**	**N**
Do you have any changes in the color or size of warts or moles?	**Y**	**N**

8. GENITOURINARY:

Do you have burning or pain when you urinate?	**Y**	**N**
Do you have trouble with losing urine when you cough or sneeze?	**Y**	**N**
Have you ever passed blood in your urine?	**Y**	**N**
Have you ever had herpes?	**Y**	**N**

9. MUSCULOSKELETAL:

Do you ever have a problem with back pain?	**Y**	**N**
Does your back pain interfere with your work or activities?	**Y**	**N**
Do you have joint pain or stiffness (arthritis)?	**Y**	**N**
Do you have trouble walking or using your hip, knee joints?	**Y**	**N**

10. RESPIRATORY:

Do you have:	**Y**	**N**
Frequent chest colds?	**Y**	**N**
Pneumonia?	**Y**	**N**
A constant or bothersome cough?	**Y**	**N**
Coughing or blood?	**Y**	**N**
Difficulty breathing?	**Y**	**N**
Wheezing or whistling in your chest?	**Y**	**N**

11. WOMEN ONLY:

Did you have any pregnancies?	**Y**	**N**
How many? _____		
Have you had any lumps in your breast?	**Y**	**N**
Have you had any abnormal bleeding from the vagina in the past year?	**Y**	**N**
Have you passed the menopause or change?	**Y**	**N**
Do you have any prolapsed (*falling out*) of the vagina or uterus?	**Y**	**N**
Have you had a hysterectomy?	**Y**	**N**
Do you have any vaginal drainage?	**Y**	**N**

12. LIVING ARRANGEMENTS:

Do you own your home?	**Y**	**N**
Do you rent your home?	**Y**	**N**
Do you live alone?	**Y**	**N**
Do you have a Will?	**Y**	**N**
Do you have a Living Will?	**Y**	**N**
Do you need other legal assistance?	**Y**	**N**

13. OCCUPATIONAL:

Are you presently employed?	**Y**	**N**
Does or did your work involve exposure to dust, noise, radioactivity, etc?	**Y**	**N**
Are you limited at work because of disability?	**Y**	**N**
Are you retired?	**Y**	**N**

Types of work you have done: _____

_____

14. SOCIAL HISTORY:

Have you recently lived o traveled outside the U.S.?	**Y**	**N**
Do you eat less than 3 meals a day?	**Y**	**N**
Do you have special food customs or restrictions?	**Y**	**N**
Do you use any community services now?	**Y**	**N**

15. PERSONAL HABITS:

Have you ever smoked tobacco?	**Y**	**N**
Are you a regular smoker now?	**Y**	**N**

Number of cigarettes per day ___ Cigars ___ Pipe ___
How long have you been smoking? _____ years
Check if you regularly drink:
Hard liquor _____oz per day
Beer ___ bottle per day ___ 2 bottles ___ 3 or more
Wine ___ glass per day ___ 2 glasses ____3 or more
Do you drink coffee? ___ Yes ___ No ____ cups per day
Do you exercise? _____
Regularly ____ Occasionally ____ Rarely
Have you used any of the following?
Marijuana _____ LSD _____ Heroin ____ Cocaine ___
Speed _____ Other similar substances _____

HERSHMAN
MEDICAL CENTER

RELEASE AUTHORIZATION

I, _____, authorize Hershman Medical Center to release my medical information (lab results, x-ray reports, health status, etc.) to the following persons.

1. _____relationship _____ Ph._____
2. _____relationship _____ Ph. _____
3. _____relationship _____ Ph. _____
4. _____relationship _____ Ph. _____

Patient's signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge and agree that I have received a copy of **Hershman Medical Center**'s Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Date

FOR CLINIC USE ONLY:

Drs. Hershman made the following good faith efforts to obtain the above-reference individual's written acknowledge of receipt of the Notice Privacy Practices:

The patient received a written description of their rights regarding their medical information in an effort to educate them to the new policy and procedures as set forth by HIPAA Privacy Regulation. The Patient's signature on this notice of acknowledgement form indicates the patient has received full disclosure from
Hershman Medical Center, PA.

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Hershman Medical Center (HMC – the provider of medical services) and yourself, the patient, who is receiving medical services, or for a minor, under 18 years old. You acknowledge that you are financially responsible for the payment(s) of all medical bills incurred on today's visit.

All charges for services rendered are due and payable at the time of service.
MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform HMC of the current address and phone number for the patient and the responsible party.
- Present all current insurance card(s).
- Verify that the information is current by signing our data sheet.
- Pay any required co-pay at the time of the visit.

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 Service Charge. Once notice is received of the returned check, HMC will send out a letter to notify the Responsible Party of the returned check.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that HMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the Responsible Party for a minor patient(s). Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Responsible Party Name (Please Print) _____

Responsible Party Signature _____ Date _____

HEALTH CARE ADVANCE DIRECTIVES
The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withholds, or withdraws life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions.

By law, hospitals, nursing home, home health agencies, hospices, and health maintenance organizations (HMO insurances) are required to provide their patients with written information, such as this, concerning heath care advance directives. However, you are not required to complete an advance directive. You may change or cancel an advance directive at any time. Any changes or cancellation must be in writing, signed, and dated.

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a "living will" because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

Types of advance directives: A Living Will, A Health Care Surrogate Designation

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You may also want to give them a copy and notify them of any changes.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

I am certifying that I have been educated on my right to exercise an Advanced Directive. However, I declare on this _____ (day) of _____ (month), _____ (year), that I, _____, do not wish to complete an advance directive at this time.

I, _____, have an existing Advanced Directive and declare on this _____ (day) of _____ (month), _____ (year) to bring a copy to Hershman Medical Center**.**

I, _____,wish to exercise an Advanced Directive and declare on this _____ (day) of _____ (month), _____ (year) to create one. (*Please ask the front desk receptionist for a packet to complete. Please turn in completed packet to the front desk receptionist to retain on file.)*