PRE-VISIT FORM

LIFESPAN MEDICAL ASSOCIATES

PATIENT'S NAME: _____DATE_____

INSURANCE_____Policy #_____ DOB: _____

TELEPHONE: _____ EMAIL:_____

Your medical history is very important to your doctor. The more information you can give him, the more successful he will be in providing you with complete medical care. Remember that all answers will be kept strictly confidential.

PAST MEDICAL HISTORY

In the space provided below, please list all illnesses, accidents, hospital admits and important visits to the doctor. Please give the date (or approximate date) and your age at the time of the event. (Do not leave out any event. Include more information than you think is necessary).

DATE	ILLNESS

Please check YES or NO to indicate if you have ever had any of these diseases

	YES	NO		YES	NO
Head injury			Diverticulitis		
Convulsions			Colon Disease		
Stroke			Rectal Disease/Hemorrhoids		
Nervous Disease			Intestinal Disease		
Epilepsy			Liver Disease		
Cancer			Hepatitis		
TB			High Blood Pressure		
Asthma			Heart Disease		
Emphysema			Arthritis		
Pneumonia			Bone Disease		
Lung disease			Gout		
Artery Disease			Muscular Disease		
Vein Disease			Adrenal Disease		
Bleeding Disorders			Diabetes		
Anemia			Thyroid Disease		
Blood Disease			Kidney Disease		
Gonorrhea			Kidney Stones		
Syphilis			Kidney Infections		
HIV/AIDS			Ovary Disease		
Venereal Disease			Testicular Disease		
Gall Bladder Disease			Hernia		
Ulcer Disease			Cervical Disease		
Breast Disease			Uterine Disease		

Details:

HAVE YOU HAD ANY OF THESE TESTS PERFORMED?				
	YES	NO	DATE	Reason
EKG				
Echocardiogram				
Treadmill/stress test				
Heart Cath				
Chest x-ray				
Bronchoscopy				
MRI				
CT Scan				
Bone Scan				
Angiogram				
Mammogram				
Breathing Tests				
Colonoscopy				
Gastroscopy				
Biopsy of any type				

SOCIAL HISTORY

PLACE OF BIRTH: _____

MARITAL HISTORY: Single□ Married □ Divorced □ Widowed □

EDUCATIONAL HISTORY: (Please circle the highest year you reached in school).

Elementary 1 2 3 4 5 6 7 8 College 1 2 3 4

High School 1 2 3 4 Postgraduate: _____

SMOKING:

Do you now smoke? YES □ NO □

How long? _____

How much? _____

Did you smoke at any time in the past? YES □ NO □

How long? _____

How much? _____

When did you quit? _____

Why did you quit? _____

DRINKING:

Do you drink? YES □ NO □

How many drinks per day (check one) □0 □1-2 □3-4 □5-6 □ More than 6 per day

MEDICATIONS Please list all medications that you are now taking or have taken in the past. For each medication list the name of the drug, the reason you were taking it, the dosage, and how often.

DRUG NAME	DOSAGE	HOW OFTEN	REASON TAKEN

Over the Counter Medication		
Do you take any herbal medication? circle	**YES**	**NO**
Echinacea, Ephedra, Garlic, Gingko, Ginseng, Kava, Valerian, St. Johns Wart (circle any that apply)		
Multi Vitamins		
Blood Thinners		
Coumadin		
Aspirin		

Do you see any of the specialists listed below?			
	Yes	**No**	**NAME**
Cardiologist (heart)			
Endocrinologist (diabetes and metabolism doctor)			
ENT (ears, nose, throat)			
Family Doctor			
Gastroenterologist (stomach and intestines)			
Hematologist (blood doctor)			
Another primary care physician			
Nephrologist (kidney doctor)			
Neurologist (nerve doctor)			
OB/GYN			
Oncologist (cancer doctor)			
Orthopedist (bone doctor)			
Pulmonologist (lung doctor)			
Rheumatologist (Arthritis doctor)			
Surgeon			
Urologist (urine doctor)			
Other: _____			

Allergies

(Agent and reaction)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS	Yes	No
GENERAL Do you feel depressed a lot of the time?		
Has there been any unusual weight gain or loss recently?		
SKIN Have you noticed:		
Any skin rashes or itching		
Any growth on your skin that bothers you?		
Any sores or wounds that do not heal?		
Any change in color or size of moles?		
EYES Date of last eye exam._____		
Have you had		
Cataracts?		
Glaucoma?		
EAR NOSE & THROAT Do you have		
Any trouble hearing?		
Earaches or discharge from your ears?		
Drainage down the back of your throat?		
Frequent or severe nosebleeds?		
Persistent hoarseness?		
RESPIRATORY SYSTEM Do you have:		
A constant or bothersome cough?		
Coughing of blood?		
Sputum or phlegm between colds?		
Difficulty breathing?		
Have you noticed any whistling or wheezing in your chest?		
Do you snore or have known sleep apnea?		
CARDIOVASCULAR SYSTEM		
Do have pain tightness or pressure in the front of your chest?		
Do have pain, tightness or pressure in the back of your chest?		
If yes, is it when walking fast, working hard or when excited?		
Have you ever been told that your EKG was abnormal?		
Do you have swelling of your feet or ankles?		
Does your heart ever beat fast or irregularly?		
Do you have cramps in the calf muscles when you walk?		
Do you ever awaken at night with difficulty breathing?		
GASTROINTESTINAL SYSTEM		
Have you recently had any change in your eating habits?		
Have you recently noted any trouble swallowing?		
Do you have a lot of indigestion or heartburn?		

REVIEW OF SYSTEMS *(continued)*	**Yes**	**No**
Do you have frequent loose stools or diarrhea?		
Do you have a poor appetite?		
Do you ever awaken at night with the feeling of fullness?		
Have you ever passed blood from your rectum?		
Have you ever had black or tarry stools?		
Have you noticed any recent changes in your bowel movements?		
Do you take laxatives regularly?		
Do you have frequent nausea and or vomiting?		
GENITOURINARY Do you have:		
Anything wrong with your genitals (privates)?		
Burning or pain when you urinate?		
To pass water frequently?		
Trouble passing water?		
To get up at night to urinate?		
Trouble with losing urine when you cough or sneeze?		
A problem dribbling urine?		
MUSCULOSKELETAL		
Do you have a problem with back pain?		
Do you have joint pain or stiffness?		
Which joints? _____		
NERVOUS SYSTEM Do you have frequent or severe headache?		
Do you often have spells of dizziness or faintness or light-headedness?		
Have you recently fainted?. Blacked out or lost consciousness?		
Have you ever had convulsions or fits?		
Do you have numbness or tingling in your head, arms or legs?		
Do you consider yourself a nervous person?		
Do you cry a lot for no reason?		
Have you ever had an urge to commit suicide?		
WOMEN ONLY		
Are your menstrual periods irregular?		
Are your periods heavy?		
Frequency of periods-_____		
Have you passed the menopause or change?		
Do you have hot flashes?		
Have you had any discharge?		
Are you using any birth control measures?		
Do you have masses or lumps in your breasts?		
Do you have discharge from your breasts?		

FAMILY HISTORY

For each of the persons listed below	STATE OF HEALTH	ILLNESSES	IF DECEASED, AGE & CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			
SPOUSE			
CHILDREN			
GRANDCHILDREN			

Please check YES or NO if any of your ***family members*** have had any of the following disease. For each YES answer indicate (or approximate) date of onset and give brief description of the course of the disease at the bottom of this sheet.

	YES	NO		YES	NO
Head injury			Diverticulitis		
Convulsions			Colon Disease		
Stroke			Rectal Disease/Hemorrhoids		
Nervous Disease			Intestinal Disease		
Epilepsy			Liver Disease		
Cancer			Hepatitis		
TB			Blood Transfusion		
Asthma			High Blood Pressure		
Emphysema			Heart Disease		
Pneumonia			Arthritis		
Lung disease			Bone Disease		
Artery Disease			Gout		
Vein Disease			Muscular Disease		
Bleeding Disorders			Adrenal Disease		
Anemia			Diabetes		
Blood Disease			Thyroid Disease		
Gonorrhea			Kidney Disease		
Syphilis			Kidney Stones		
HIV/AIDS			Kidney Infections		
Venereal Disease			Alcoholism		
Gall Bladder Disease			Mental Illness		
Ulcer Disease			Surgery		
Breast Diseases			Other Disease		

LIFESPAN MEDICAL ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity (Lifespan Medical Associates). I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The covered Entity shall not be liable for the acts or omissions of independent contractors.

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for charges not paid by insurance. I understand this amount is due upon billing.

INSURANCE COVERAGE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)