The Smarter Choice for Care

MIDDLESEX HOSPITAL
PRIMARY CARE

Dear New Patient,

We are pleased to welcome you as a patient of Middlesex Hospital Primary Care. Each and every day, the people at Middlesex Hospital Primary Care work to provide patient-centered, compassionate care to patients throughout our communities. We're proud of the association we have with one of the top hospitals in Connecticut, and we are confident that we can provide you with the best care possible. Thank you for choosing Middlesex Hospital Primary Care. We look forward to managing your health.

Sincerely,
Middlesex Hospital Primary Care

Patient Name: _____

First Appointment Date: _____
First Appointment Location: _____
First Appointment Provider Name: _____

Forms to Complete: **(We will accept and we appreciate completed forms prior to your visit)**

- □ Form 1: Authorization to Release Health Information (Used to obtain previous records)
- □ Form 2: Patient Information Form
- □ Form 3: Consent for Treatment/Release Information/Financial/HIPAA/Photo
- □ Form 4: Statement of Non Discrimination
- □ Form 5: Authorization to Disclose Health Information to Family & Friends
- □ Form 6: Health History Questionnaire (3 pages)

Please Bring the Following to your visit:

- □ Medical records (Complete and return Form 1 prior to first visit)
- □ Insurance card
- □ Required Co-Pay
- □ Completed patient forms (All 5 Forms)
- □ All medications you are currently taking, in original containers

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MIDDLESEX HOSPITAL PRIMARY CARE

FORM 1

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: DOB:

I hereby authorize Middlesex Hospital Primary Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Method: ☐Mail ☐Pick up ☐Fax

Medical Group Name:_____

Addresss: _____

City :_____State:_____ Zip:_____

Fax: (If needed):_____

Phone: _____

Send the Medical Records To:

Method: ☐Mail ☐Pick up ☐Fax

Name:_____

Address: _____

City :_____State:_____ Zip:_____

Fax: (If needed):_____

Phone: _____

What is the Purpose of Health Information Release

☐Personal	☐New Physician	☐Social Security Disability	☐Other: _____
☐Primary Care Physician	☐Medical Ins. Claim	☐Life Insurance	
☐Consultation	☐Worker's Com	☐Attorney	

Describe the Health Information to be Released

Service Dates: from:_____to:_____Information Needed By: _____

☐Complete Medical Record	☐Other: _____		
☐History and Physical	☐EKG's	☐Laboratory Results	☐Hospital Notes
☐Immunization Records	☐Pathology Reports	☐Radiology Reports	☐Clinic Notes
☐Hospital Discharge Summary	☐Operative Reports	☐Radiology Images	☐Billing Information

I understand that Middlesex Hospital Primary Care will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Middlesex Hospital Primary Care. I understand that I may not be able to revoke this Authorization if Middlesex Hospital Primary Care has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____

_____ _____

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

_____

Printed Name of Person Signing (If Not the Patient) **Relationship to Patient**

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FORM 1 (page 2)

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

> "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 C.F.R. § 2.32)

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

The Smarter Choice for Care

MIDDLESEX HOSPITAL PRIMARY CARE

FORM 2: PATIENT INFORMATION

Demographics

Last Name: First Name: MI:

Address: Mailing Address:

City: State: Zip:

Date of Birth: Sex: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Responsible Party (if under 18):

Contact Information

Home Phone Cell Phone

Appointment Reminder Preference: (Please choose one) ☐ Home or ☐ Cell If Cell: ☐ Voice or ☐ Text

Email Address for Patient Portal Use:

Emergency Contact Name: Emergency Contact Phone:

Emergency Contact Address: Relation to You:

Pharmacy Preference

Local Pharmacy Name: Local Pharmacy Address:

Mail Order Pharmacy: Mail Order Pharmacy Address:

Insurance Information: *Please bring your Insurance Card to each visit*

Additional Information

Race:

☐ White ☐ Hispanic ☐ Black-African American
☐ Asian ☐ American Indian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Unreported/Refused to Report ☐ Other Race

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ Refused to Report

Preferred Language:

☐ English ☐ Spanish ☐ Other:_____

The Smarter Choice for Care
MIDDLESEX HOSPITAL PRIMARY CARE

FORM 3: Consent for Treatment, Authorization for Release of Information, Financial Agreement and Consent for Photo ID

PRINT NAME: _____ **DOB**: _____

CONSENT FOR TREATMENT:
Permission is hereby given to the physicians and staff of Middlesex Hospital Primary Care ("MHPC"), a Middlesex Health System affiliate, to provide ordinary and necessary medical examination, diagnosis and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care as well as laboratory tests, but shall not include surgery, general anesthesia, laboratory tests for which separate consent is required under the law or other extraordinary procedures. I further consent to routine immunizations for future office visits.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Hospital. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

FINANCIAL AGREEMENT/ASSIGNMENT OF INSURANCE BENEFITS:
I understand that I am obligated to pay MHPC for services provided to me in accordance with the rates and terms of MHPC, including a "No-Show" fee of **$45 for a missed office visit and $75 for a missed comprehensive physical exam or surgical procedure appointment** if I fail to appear and did not cancel at least 24 hours in advance. In consideration for services provided or to be provided to me, I hereby assign to MHPC all basic and major medical or other insurance benefits, including, without limitation, Medicare or Medicaid benefits, to cover such expenses. In connection with such assignment, MHPC is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information (including, without limitation, copies of any plans, contract, or other documents defining or otherwise limiting the scope of insurance coverage by such carrier) as may be necessary to process any insurance claims related to my treatment by MHPC. If I am not insured, I hereby authorize MHPC to use and/or disclose my health information in order to obtain funds to cover expenses related to my treatment by MHPC. I owe and agree to pay MHPC for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by MHPC to collect the balance owed. I also authorize payment directly to MHPC or the entity providing service under the above account number that would otherwise be payable to me.

HIPAA ACKNOWLEDGEMENT:
The undersigned hereby acknowledges that I have received a copy of the Middlesex Health System Joint Notice of Privacy Policy.

CONSENT FOR PHOTO IDENTIFICATION:
I consent to MHPC taking a digital photograph of my face for purposes of patient identification. The digital photograph will remain with my electronic medical chart and will not be used for other purposes without my authorization.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

_____

Date Signature of Patient or Person Granting Authorization on Behalf of Patient

If the patient has not signed this form, please print the signer's name, relationship to the patient and, if necessary, explain why the patient did not sign.

The Smarter Choice for Care
MIDDLESEX HOSPITAL

FORM 4: Statement of Non Discrimination and Taglines

English: Middlesex Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, are deaf or hard of hearing, language assistance services are provided free of charge. Call 1-860-358-6000 or TTY 1-860-358-4499.

Español (Spanish): Middlesex Health Systems cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-358-6000 TTY: 1-860-358-4499.

Polski (Polish): Middlesex Health Systems postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-860-358-6000 TTY: 1-860-358-4499.

Italiano (Italian): Middlesex Health Systems è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso. ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-860-358-6000 TTY: 1-860-358-4499.

Português (Portuguese): Middlesex Health System cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-860-358-6000 TTY: 1-860-358-4499.

Français (French): Middlesex Health Systems respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap. ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-860-358-6000 TTY: 1-860-358-4499

繁體中文 **(Chinese)**: Middlesex Health Systems 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。注意：如果您使用繁體中文，您可以免費獲得語 言援助服務。請致電 1-860-358-6000 TTY:1-860-358-4499.

Kreyòl Ayisyen (French Creole): Middlesex Health Systems konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-860-358-6000 TTY: 1-860-358-4499. **Deutsch (German)**: Middlesex Health Systems erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab. ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-860-358-6000 TTY: 1-860-358-4499.

हंद (Hindi): Middlesex Health Systems लागू होने योग्य संघीय नागरक अधकार कानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु विकलांगता, या लग के

आधार पर भेदभाव नह ध्यान द आप हंद बोलते ह तो आपके लिए मुफ्त म भाषा 1-860-358-6000 TTY: 1-860-358-4499 पर करता है कॉल कर। न द सहायता सेवाएं उपलब्ध ह

Русский (Russian): Middlesex Health Systems соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1860-358-6000 телетайп: 1-860-358-4499.

(Arabic): ةيبرعلا

يلتزم Middlesex Health Systems بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-860-358-6000 (رقم هاتف الصم والبكم: 1-860-358-4499).

Ελληνικά (Greek): Η Middlesex Health Systems συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο. ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν.Καλέστε 1-860-358-6000 or TTY 1-860-358-4499.

Tagalog (Tagalog - Filipino): Sumusunod ang Middlesex Health Systems sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian. PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-860-358-6000 or TTY 1-860-358-4499.

Tiếng Việt (Vietnamese): Middlesex Health System tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-860-358-6000 TTY: 1-860-358-4499.

Shqip (Albanian): Middlesex Health Systems vepron në përputhje me ligjet e zbatueshme federale të të drejtave civile dhe nuk ushtron diskriminim mbi baza si raca, ngjyra, prejardhja etnike, mosha, aftësia e kufizuar ose gjinia. KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-860-358-6000 TTY: 1-860-358-4499.

Kiswahili (Swahili): Middlesex Health Systems ametimiza mahitaji ya sheria za serikali kuu na hana ubaguzi wakikabila, rangi, asili, umri, ilemavu ama jinsia. KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.Piga simu 1-860-358-6000 TTY: 1-860-358-4499.

(Farsi): ىسراف

Middlesex Health Systems از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-860-358-6000 TTY: 860-358-4499 تماس بگیرید.

How to File a Complaint of Discrimination:

It is your right to file a complaint. Registering a complaint will not change our commitment to provide you the best quality of care. It is the policy of Middlesex Hospital not to discriminate due to age, sex, race, color, religion, sexual orientation, income, education, national origin, ancestry, marital status, culture, language, disability, gender identity, or who will pay the bill. Middlesex Hospital has an internal grievance procedure providing for prompt and equitable resolutions of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its' implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services.

1. Contact the Compliance Coordinator in the Quality Improvement Department at 860-358-6151. Office hours are Monday through Friday 8:30 a.m. - 4:00 p.m. When the office is closed, you may leave a voicemail, and a staff member will return your call on the next business day.
2. In situations that require immediate assistance contact the department manager or contact the hospital operator (by dialing "0" internally or when calling from home dial 860-358-6000) and ask to speak to the nursing supervisor. You may also contact the U.S Department of Health and Human Services, Office of Civil Rights. A person can file a complaint of discrimination electronically through the Office of Civil Rights Complaint Portal, which is available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail at: U.S Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The Smarter Choice for Care

MIDDLESEX HOSPITAL PRIMARY CARE

FORM 5: AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY & FRIENDS

Name of Patient: _____ DOB: _____

Your privacy is important to us and we want to protect it as much as possible. By signing this form, you authorize Middlesex Hospital Primary Care to disclose information as requested to the individual(s) below.

Name	Relationship to Patient

AUTHORIZATION FOR RELEASE OF INFORMATION:
I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/orHIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Hospital. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

_____ _____
Signature of Patient of Person granting Authorization on behalf of patient Date:

_____ _____
Printed Name of Person Signing (If Not the Patient) Relationship to Patient

FORM 5: MHPC – Health History Questionnaire

Name: _____ DOB: _____

Current Concerns / New Problems: ❑ No concerns. ❑ Establish care with a new Primary Care Provider.

1. _____
2. _____
3. _____

Past Health History:

Have you had any of the following medical conditions?

- ❑ Acid reflux
- ❑ Anemia (low blood count)
- ❑ Anxiety / Panic attacks
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood clotting problems
- ❑ Cancer (Type: _____)
- ❑ Chronic back pain
- ❑ Constipation
- ❑ COPD / Emphysema
- ❑ Dementia / Alzheimer's
- ❑ Depression
- ❑ Diabetes / High blood sugar
- ❑ Erectile dysfunction
- ❑ Eye disorder (Specify: _____)
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Gynecological problems (Specify: _____)
- ❑ Hearing loss
- ❑ Heart disease / Heart attack
- ❑ Heart Failure
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat / palpitations
- ❑ Joint problems (Specify:_____)
- ❑ Kidney problems (Specify: _____)
- ❑ Liver problems
- ❑ Migraines / Chronic headaches
- ❑ Mobility problems
- ❑ Osteoporosis
- ❑ Prostate problems
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Sexually transmitted disease
- ❑ Skin condition (Specify: _____)
- ❑ Stomach / GI problems (Specify: _____)
- ❑ Stroke / TIA
- ❑ Substance or alcohol abuse
- ❑ Thyroid problems
- ❑ Urinary incontinence
- ❑ Urinary tract infections
- ❑ Other:_____
- ❑ Other:_____

Have you had any of the following surgeries?

- ❑ Appendectomy
- ❑ Back surgery
- ❑ Biopsy (Type: _____)
- ❑ Breast surgery
- ❑ Carotid artery surgery
- ❑ Cataract surgery
- ❑ Coronary artery bypass
- ❑ Colon surgery (Type: _____)
- ❑ C-Section(s)
- ❑ Dilation & Curettage (D&C)
- ❑ Gallbladder removal
- ❑ Gastric bypass / Weightloss surgery
- ❑ Heart stent(s)
- ❑ Hemorrhoidectomy
- ❑ Hernia repair (Type: _____)
- ❑ Hysterectomy
- ❑ Joint replacement (Type: _____)
- ❑ Pacemaker insertion
- ❑ Prostate surgery
- ❑ Tonsillectomy
- ❑ Skin graft
- ❑ Other:_____

Prior Hospitalizations:

Year:_____ Reason:_____
Year:_____ Reason:_____
Year:_____ Reason:_____
Year:_____ Reason:_____

List Health Care providers involved in your care:

_____
_____
_____
_____

Allergies: *Please include name of medication or food and type of reaction*

Name	Reaction	Name	Reaction
1)		3)	
2)		4)	

FORM 5: MHPC – Health History Questionnaire

Name: _____ DOB: _____

Current Medications: *Please include prescription medications, over-the-counter drugs, vitamins and supplements*

Name / Dose	# Tabs / Frequency	Name / Dose	# Tabs / Frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Family History: *Please indicate if any of the following conditions are present in your family members*

Relative	**Status**	**Cancer** (Specify Type)	**Diabetes**	**Heart Disease**	**High Blood Pressure**	**Mental Illness** (Specify)	**Stroke**	**Other** (Specify)
Father	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Paternal Grandfather	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Paternal Grandmother	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Paternal Other_____	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Mother	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Maternal Grandfather	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Maternal Grandmother	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Maternal Other_____	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Siblings _____	☐ Alive ☐ Deceased		☐	☐	☐		☐	
Children _____	☐ Alive ☐ Deceased		☐	☐	☐		☐	

Social History:

Marital status: ❑ Single ❑ Married ❑ Divorced / Separated ❑ Widowed ❑ In a relationship

Highest level of Education: _____ Location of Birth: _____

Occupation: _____ Occupational/Environmental Exposures: _____

Alcohol use: ❑ None ❑ Yes (Number of drinks/week: _____)

Smoking: ❑ Never ❑ Former Smoker (Quit Date: _____) ❑ Current Smoker (Number of cigs/day:_____)

Recreational drugs: ❑ None ❑ History of injection drug use ❑ Past / Current use (Specify: _____)

Diet: ❑ Diabetic ❑ Heart Healthy ❑ "Meat & Potatoes" ❑ Mediterranean ❑ Vegetarian ❑ Other_____

Do you exercise regularly? ❑ No ❑ Yes (What type and how often?_____)

Have you had a fall in the past year? ❑ No ❑ Yes

Have you traveled outside the country in the past 5 years? ❑ No ❑ Yes (Where? _____)

Do you have an Advanced Directive or Living Will? ❑ No ❑ Yes *(if yes, please make sure we receive a copy)*

Name: _____ DOB: _____

Preventive Health History: *Please indicate the date the following were performed*

	Date		Date
Last preventive health visit / Complete physical		Stress test or EKG	
Breast cancer screening (Mammogram)		Hepatitis C screening (if born 1945-1965)	
Cervical cancer screening (Pap smear)		Flu Vaccine	
Colon cancer screening (Colonoscopy)		Pneumonia Vaccine	
Lung cancer screening (CT scan for high risk only)		Shingles Vaccine	
Osteoporosis screening (Bone density)		Tetanus / TDAP Vaccine	
Prostate cancer screening (PSA)		Other:_____	

Review of Systems: *If you have experienced any of the following symptoms, please check the corresponding box.*

GENERAL
Weight gain or loss over l0 pounds ❑
More fatigue than usual ❑
Fever, chills ❑
Night sweats ❑

SKIN
Changes in your skin, hair, or nails ❑
Dryness or changes in texture ❑
Rashes ❑
Itching ❑
Jaundice or yellowing of the skin ❑
Moles that have changes in appearance ❑

HEAD
Headaches ❑
Head injuries ❑

EYES
Trouble with your vision ❑
Eyeglasses/contact lenses ❑
Eye pain, redness, excessive tearing ❑
Double vision ❑
Glaucoma ❑
Cataracts ❑

EARS
Trouble with hearing ❑
Ear infections ❑
Pain in ear ❑
Discharge (fluid) from ear ❑
Ringing in ears (tinnitus) ❑
Spinning or vertigo attacks ❑

NOSE/SINUSES
Trouble with nose/sinuses ❑
Constant Postnasal drip ❑
Significant Nasal congestion ❑
Nosebleeds ❑

MOUTH/THROAT
Recent change in taste ❑
Any bleeding of lips, gums, tongue, mouth, throat ❑
Persistent sore throat ❑
Hoarse voice ❑

NECK
Swollen glands or lumps ❑
Stiffness or loss of motion ❑
Neck pain ❑

BREAST
Breast lumps or bumps ❑
Discharge from the nipple ❑
Pain in the breast ❑

CARDIOVASCULAR
Swelling in legs ❑
Difficult or uncomfortable breathing ❑
Needing to sleep upright to breathe better ❑
Chest pain, pressure tightness with exertion ❑
Racing, pouding heart beat ❑
Irregular heart beat ❑
Told you had high blood pressure ❑
Told you had a heart murmur ❑

RESPIRATORY
Wheezing ❑
Regular Coughing ❑
Coughing up phlegm (mucus) ❑
Coughing up blood ❑
Asthma ❑
Exposure to someone with TB ❑

GASTROINTESTINAL
Trouble/pain with swallowing ❑
Frequent Heartburn ❑
Pain after eating ❑
Abdominal pain/discomfort ❑
Nausea/vomiting ❑
Vomiting up blood ❑
Excessive Gas ❑
Changes in bowel habits ❑
Constipation ❑
Diarrhea ❑
Unusual colored stools ❑
Bleeding from rectum ❑
Hemorrhoids ❑
Groin pain with lifting or straining ❑

GENITOURINARY
Difficulty passing urine ❑
Frequent urination ❑
Urinating more than once at night ❑
Any pain or burning with urinating ❑
Leak urine or wet yourself ❑
Urine appeared bloody, brown or reddish ❑
Urinary infection ❑
Passed kidney stones ❑

FOR MEN:
Sores on or discharge from the penis ❑
Lump on the testicle ❑
Pain in the testicles ❑

FOR WOMEN:
Sores on or discharge from the vagina ❑
Menstrual cycle irregularities ❑
Unusual vaginal discharge or odor ❑
Unexpected vaginal bleeding ❑

SEXUAL
Am sexually active ❑
More than one sexual partner ❑
Interested in getting pregnant ❑
Not using any contraception ❑
Worried about sexually transmitted infections ❑
Problems/concerns about sexual function ❑
Had an unwanted sexual experience ❑

PERIPHERAL VASCULAR
Cramps, aches, or numbness in legs while walking ❑
Swollen feet or ankles ❑
Fingertips change color when cold ❑
Varicose Veins ❑

MUSCULOSKELETAL
Pain in your joints ❑
Swelling, redness, warmth in joints ❑
Back or shoulder pain ❑
Back stiffness ❑
Disc problems ❑
Weakness in muscles ❑
Any bone fractures ❑

NEUROLOGICAL
Dizzy spells or lightheadedness ❑
Any fainting spells ❑
Convulsions or seizures ❑
Loss of consciousness ❑
Any speech problems ❑
Trouble staying alert ❑
Problems with memory ❑
Numbness or tingling in hands or feet ❑
Weakness in particular part of body ❑

HEMATOLOGICAL
Bleed or bruise easily ❑
Received any blood transfusions ❑

ENDOCRINE
Do you ever feel too hot or too cold ❑
Excessive thirst ❑

PSYCHIATRIC
Seen a counselor/therapist or psychiatrist ❑
Experience mood swings ❑
Feel depressed ❑
Feel a loss of interest in life ❑
Feel frequently worried or nervous ❑
Feel you should cut down on drinking ❑

Reviewed by Primary Care Provider: _____ Date: _____