**NEW PATIENT HEALTH HISTORY FORM**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

|  |  |  |
| --- | --- | --- |
| **Name** *(Last, First, M.I.):* | * M  F
 | **DOB:** |
| **Marital status:** | * Single  Partnered  Married  Separated  Divorced  Widowed
 |
| **Contact Phone** |
| **A ddress** |
| **Email** |
| **Previous or referring doctor:** | **Date of last physical exam:** |

**Notice of Patient Privacy/Patient Consent Form**

I understand that as part of my healthcare, the physicians of One to One Health originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for serv ices provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

One to One Health Notice of Privacy Practices provides specific information and complete description of how my personal information may be used and disclosed. I understand that a copy of the Notice of Priv acy Practices is av ailable at the front desk and understand that I have the right to rev iew the notice prior to signing this consent. I understand that One to One Health reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that One to

One Health is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that One to One Health has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any rev ised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our

privacy practices and policies, please contact the person listed at the end of this document.

NOTE: One to One Health must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want One to One Health to have access to disclose your Private Health Information to your spouse or any other person during your treatment, please sign below.

Patient Signature Date

**PERSONAL HEALTH HISTORY**

|  |  |
| --- | --- |
| **Childhood illness:** | * Measles  Mumps  Rubella  Chickenpox  Rheumatic Fev er  Polio
 |
| **Immunizations and dates:** | * Tetanus
 | * Pneumonia
 |
| * Hepatitis
 | * Chickenpox
 |
| * Influenza
 | * MMR *Measles, Mumps, Rubella*
 |
| **List any medical problems that other doctors have diagnosed** |
|  |
| **Surgeries** |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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| --- |
| **Other hospitalizations** |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever had a blood transfusion?** |  | Yes |  | No |

*Please turn to next page*

|  |
| --- |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** |
| Name the Drug | Strength | Frequency Tak en |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **A llergies to medications** |
| Name the Drug | Reaction You Had |
|  |  |
|  |  |
|  |  |
|  |
| **HEALTH HABITS AND PERSONAL SAFETY** |
|  |
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. |
| **Exercise** | * Sedentary (No exercise)
 |
| * Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
 |
| * Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
 |
| * Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
 |
| **Diet** | Are you dieting? |  | Yes |  | No |
| If yes, are you on a physician prescribed medical diet? |  | Yes |  | No |
| # of meals you eat in an av erage day ? |
| Rank salt intak e | * Hi
 | * Med
 | * Low
 |
| Rank fat intak e | * Hi
 | * Med
 | * Low
 |
| **Caffeine** | * None
 | * Coffee
 | * Tea
 | * Cola
 |
| # of cups/cans per day ? |
| **Alcohol** | Do you drink alcohol? |  | Yes |  | No |
| If yes, what kind? |
| How many drinks per week ? |
| Are you concerned about the amount you drink? |  | Yes |  | No |
| Have you considered stopping? |  | Yes |  | No |
| Have you ev er experienced blackouts? |  | Yes |  | No |
| Are you prone to “binge” drinking? |  | Yes |  | No |
| Do you drive after drinking? |  | Yes |  | No |
| **Tobacco** | Do you use tobacco? |  | Yes |  | No |
| * Cigarettes – pk s./day
 | * Chew - #/day
 | * Pipe - #/day
 | * Cigars - #/day
 |
| * # of y ears
 | * Or y ear quit
 |
| **Drugs** | Do you currently use recreational or street drugs? |  | Yes |  | No |
| Have you ev er giv en yourself street drugs with a needle? |  | Yes |  | No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sex** | Are you sexually active? |  | Yes |  | No |
| If yes, are you trying for a pregnancy? |  | Yes |  | No |
| If not trying for a pregnancy list contraceptiv e or barrier method used: |
| Any discomfort with intercourse? |  | Yes |  | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? |  | Yes |  | No |
| **Personal Safety** | Do you live alone? |  | Yes |  | No |
| Do you have frequent falls? |  | Yes |  | No |
| Do you have vision or hearing loss? |  | Yes |  | No |
| Do you have an Advance Directive or Living Will? |  | Yes |  | No |
| Would you like information on the preparation of these? |  | Yes |  | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? |  | Yes |  | No |

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| **FAMILY HEALTH HISTORY** |
|  |
|  | AGE | SIGNIFICANT HEALTH PRO BLEMS |  | AGE | SIGNIFICANT HEALTH PRO BLEMS |
| **Father** |  |  | **Children** | * M
* F
 |  |
| **Mother** |  |  | * M
* F
 |  |
| **Sibling** | * M
* F
 |  | * M
* F
 |  |
| * M
* F
 |  | * M
* F
 |  |
| * M
* F
 |  | **Grandmother***Maternal* |  |  |
| * M
* F
 |  | **Grandfather***Maternal* |  |  |
| * M
* F
 |  | **Grandmother***Paternal* |  |  |
| * M
* F
 |  | **Grandfather***Paternal* |  |  |

|  |
| --- |
| **MENTAL HEALTH** |
|  |
| Is stress a major problem for you? |  | Yes |  | No |
| Do you feel depressed? |  | Yes |  | No |
| Do you panic when stressed? |  | Yes |  | No |
| Do you have problems with eating or your appetite? |  | Yes |  | No |
| Do you cry frequently? |  | Yes |  | No |
| Have you ev er attempted suicide? |  | Yes |  | No |
| Have you ev er seriously thought about hurting yourself? |  | Yes |  | No |
| Do you have trouble sleeping? |  | Yes |  | No |
| Hav e you ev er been to a counselor? |  | Yes |  | No |

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| --- |
| **WOMEN ONLY** |
|  |
| Age at onset of menstruation: |
| Date of last menstruation: |
| Period ev ery days |
| Heavy periods, irregularity, spotting, pain, or discharge? |  | Yes |  | No |
| Number of pregnancies Number of live births  |
| Are you pregnant or breastfeeding? |  | Yes |  | No |
| Have you had a D&C, hysterectomy , or C esarean? |  | Yes |  | No |
| Any urinary tract, bladder, or kidney infections within the last year? |  | Yes |  | No |
| Any blood in your urine? |  | Yes |  | No |
| Any problems with control of urination? |  | Yes |  | No |
| Any hot flashes or sweating at night? |  | Yes |  | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? |  | Yes |  | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? |  | Yes |  | No |
| Date of last pap and rectal exam? |
|  |
| **MEN ONLY** |
|  |
| Do you usually get up to urinate during the night? |  | Yes |  | No |
| If yes, # of times  |
| Do you feel pain or burning with urination? |  | Yes |  | No |
| Any blood in your urine? |  | Yes |  | No |
| Do you feel burning discharge from penis? |  | Yes |  | No |
| Has the force of your urination decreased? |  | Yes |  | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? |  | Yes |  | No |
| Do you have any problems emptying your bladder completely? |  | Yes |  | No |
| Any difficulty with erection or ejaculation? |  | Yes |  | No |
| Any testicle pain or swelling? |  | Yes |  | No |
| Date of last prostate and rectal exam? |  |  |
|  |
| **OTHER PROBLEMS** |
|  |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Skin |  | Chest/Heart |  | Recent changes in: |
|  | Head/Neck |  | Back |  | Weight |
|  | Ears |  | Intestinal |  | Energy lev el |
|  | Nose |  | Bladder |  | Ability to sleep |
|  | Throat |  | Bowel |  | O ther pain/discomfort: |
|  | Lungs |  | Circulation |  |

**EMERGENCY CONTACT INFORMATION**

**IN CASE OF EMERGENCY, WHO MAY WE CONTACT FOR YOU?**

|  |
| --- |
| Name |
| Cell Phone |
| Work Phone |
| Address |
| This person’s relation to you |

**Patient Privacy Form**

**Patient’s Name:**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and if so you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

* Protected health information may be disclosed or used for treatment, payment or health care operations. 
* All other disclosures by the practice will require specific authorization by you unless required by law. 
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a copy. 
* The Practice reserves the right to change the Notice of Privacy Policies. The new policy will be posted in the lobby and on the web site. 
* The patient has the right to restrict the uses of their information used for treatment, payment or operations, but the Practice does not have to agree to those restrictions.



**Patient/Guardian: Date:** 

**Practice Representative: Date:** 