

MEDICAL HISTORY FORM

Patient's Name _____ How do you want us to address you? _____
 DOB ____/____/____ Age _____ Height _____ Weight _____ Referring Dr. _____
 Why are you here to see the doctor? _____

MEDICATIONS

MEDICATIONS TAKEN REGULARLY	REASON	DOSE	How Often?	Start Date

MEDICINE ALLERGIES	REACTION
FOOD ALLERGIES	REACTION

PROCEDURE/SURGERY	YEAR

PAST MEDICAL HISTORY

DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO
Anemia			Heart Murmur			Mitral Valve Prolapse		
Arthritis			Diabetes			Rheumatic Fever		
Asthma			Glaucoma			Skin Cancer		
Bleeding Problem			Hepatitis			Stroke		
Blood Transfusion			High Blood pressure			Thyroid Disease		
Cancer (Other)			HIV/AIDS			Tuberculosis		
Heart Disease			Kidney Disease					

If yes to any of the above, please describe the condition: _____

YOUR FAMILY HISTORY

DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO	DIAGNOSIS	Yes	NO
Breast Cancer			Diabetes			Heart Disease		
Melanoma			Stroke			Kidney Disease		
Other Cancer			High Blood Pressure			Depression		

If yes to any of the above, please identify your relation to the family member and age of diagnosis: _____

TOBACCO USE: YES NO FORMER
 Type _____ # of Years _____
 Units per day _____ Year quit _____

DRINKS ALCOHOL: YES NO FORMER
 Type _____ Amount _____
 Frequency _____ Last drink _____

EXERCISE: YES NO
 Can you walk up 2 flights of stairs? YES NO

Occupation _____

REVIEW OF SYSTEMS

Patient Name _____

Date _____

Are you currently experiencing any of the following?

CONSTITUTIONAL

- YES NO
- Chills
 - Fatigue
 - Fever
 - Malaise
 - Night Sweats
 - Weight gain
 - Weight Loss

Other: _____

HEENT

- YES NO
- Ear drainage
 - Ear pain
 - Eye discharge
 - Eye pain
 - Hearing loss
 - Nasal drainage
 - Sinus pressure
 - Sore throat
 - Visual changes

Other: _____

RESPIRATORY

- YES NO
- Chronic cough
 - Cough
 - Known TB exposure
 - Shortness of breath
 - Wheezing

Other: _____

CARDIOVASCULAR

- YES NO
- Chest pain
 - Claudication
 - Edema (swelling)
 - Palpitations

Other: _____

GASTROINTESTINAL

- YES NO
- Abdominal pain
 - Blood in stools
 - Change in stools
 - Constipation
 - Diarrhea
 - Heartburn
 - Loss of appetite
 - Nausea
 - Vomiting

Other: _____

BREAST

- YES NO
- Nipple discharge
 - Breast lump
 - Inverted nipples
 - Breast pain
 - Breast swelling

Other: _____

METABOLIC/ENDOCRINE

- YES NO
- Brittle hair
 - Brittle nails
 - Cold intolerance
 - Hair changes
 - Heat intolerance
 - Hirsutism (excessive bodily hair)
 - Polydipsia (excessive thirst)
 - Polyphagia (over eating)

Other: _____

NEUROLOGICAL

- YES NO
- Dizziness
 - Extremity numbness
 - Extremity weakness
 - Gait disturbance
 - Headache
 - Memory loss
 - Seizures
 - Tremors

Other: _____

PSYCHIATRIC

- YES NO
- Anxiety
 - Depression
 - Insomnia

Other: _____

INTEGUMENTARY

- YES NO
- Contact allergy
 - Hives
 - Itching
 - Mole changes
 - Rash
 - Skin lesion

Other: _____

MUSCULOSKELETAL

- YES NO
- Back pain
 - Joint pain
 - Joint swelling
 - Muscle weakness
 - Neck pain

Other: _____

HEMATOLOGIC/LYMPHATIC

- YES NO
- Easy bleeding
 - Easy bruising
 - Lymphadenopathy (swelling of lymph nodes)

Other: _____

GENITOURINARY

- YES NO
- Painful/difficult urination
 - Excessive urination
 - Blood in urine
 - Incontinence

Other: _____

IMMUNOLOGIC

- YES NO
- Environmental allergies
 - Food allergies
 - Seasonal allergies
 - Limited range of motion
 - Redness or tenderness

Other: _____

PASTS TESTS/DIAGNOSTICS/LABS:

DATE	TYPE

I have reviewed the above recorded information

Physician Signature _____

Date _____

Preferred Pharmacy Selection

Please indicate your preferred pharmacy(ies) for any medications we may prescribe:

Pharmacy Name	
Address and/or Cross Streets	
Phone Number	

Pharmacy Name	
Address and/or Cross Streets	
Phone Number	

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system to improve the quality of our services. This system also allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record. This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for ARIZONA COMMUNITY SURGEONS, PC to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Patient Name (Print)

Patient or Parent/Guardian Signature

Date

I understand that under the Health Insurance Portability & Accountability Act of 1998 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Surgeons, PC (“ACS”), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

Signature: _____

Patient Name: _____

Relationship to Patient: _____

Date: _____

ACS OFFICE USE ONLY:

I attempted to obtain the patient’s signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Employee Name/Initials: _____

Reason: _____
