Hearts South, PC
Specialists in Cardiovascular Care

Darius G. Aliabadi, MD, FACC, FSCAI
Donna L. Trimnel, Administrator

Hollie B. Crutchfield, DNP, CRNP, FNP-BC
Marla Hodge, CRNP, FNP-BC

Medical Information Release

Due to federal privacy guidelines under the Health Insurance Portability and Accountability Act (HIPAA), we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to family members, caregivers, and friends you have designated, about your HEALTH INFORMATION. Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, mail or e-mail as needed for your care to only those identified below. Powers of Attorney would be listed separately.

Please list names, date of birth and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

I _____ (patient name) give my authorization to the following individual(s) listed below to discuss my medical care with you and/or your staff on my behalf.

Names	Date of Birth	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below any health information that you do not want to be given out.

_____

_____

☐ **I DO NOT want you to discuss my medical care with ANYONE other than myself.**

Our office staff may attempt to contact you by telephone concerning your upcoming appointments or test results. If we are unable to reach you at that time, please indicate below your choice for the best way to contact you:

☐Family member at my home
☐Leave a message at my place of business
☐Voice message on my cell phone
☐Answer machine at my home

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed or until we receive written notification from you to revoke it.

Signature _____ Date _____

Witness _____ Date _____

Revised 07/31/09
Form-Med.rel.4/14/03-#1

Doctors Building, Suite 403 · 1118 Ross Clark Circle · Dothan, Alabama 36301

(334) 793-5672 · 1-800-293-5672 · FAX: (334) 794-0378

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PATIENT INFORMATION/MEDICAL COST AGREEMENT TO PAY

Patient's Name: _____ Age: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Marital Status: (circle one) S M W D Race: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____ Extension: _____

Social Security Number: _____ Referring Physician: _____

Place of Employment: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

If minor, Responsible Party: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Phone: _____

In case of emergency, who should be notified? _____

Phone No.: _____ Relationship to Patient: _____

INSURANCE INFORMATION

1. PRIMARY:

_____ Contract # _____ Group # _____
Name of Carrier

Insured's Information If Other Than Patient:
Date of Birth: _____ Relationship to Patient: _____ Place of Employment: _____

2. SECONDARY:

_____ Contract # _____ Group # _____
Name of Carrier

Insured's Information If Other Than Patient:

Date of Birth: _____ Relationship to Patient: _____ Place of Employment: _____

PATIENT'S OR AUTHORIZED SIGNATURE: I authorize the release of any medical information needed to process my insurance claims. I also request payment of benefits to Hearts South, P.C. for services rendered. This signature shall suffice for all claims on a continuing basis. A copy of this authorization may be used in place of original.

SIGNED: _____ DATE: _____

RELEASE OF MEDICAL RECORD: In order to insure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to Hearts South, P .C., my physician, a designated referring physician and/or the provider, if any, who referred me here.

SIGNED: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices from Hearts South, P.C.

_____ _____
Patient or Personal Representative Date

MEDICAL COST AGREEMENT TO PAY
(continued)

The Patient and Responsible Party listed above hereby agree to pay any and all amounts and charges submitted by Hearts South, P.C. on behalf of the professional corporation set forth above for services rendered by any and all physicians who are now employed or become employed by such professional corporations or affiliated with Hearts South, P.C., (hereinafter referred to as "Physician"), or any of their agents, employees or contractors, during the course of treatment for the Patient, including hospitalization, unless such parties are otherwise obligated to accept payment solely from a third party. The Patient and the Responsible Party hereby acknowledge, understand, and agree that they are financially responsible for payment for such professional services even though there may be insurance or third party coverage, and agree that failure to make payment when requested is the basis for legal action, and all agree to pay any and all costs of collection including a reasonable attorney's fee to the extent permitted by law. The Patient and Responsible Party hereby acknowledge their understanding that the payment is due upon receipt of invoice statement, and agree to pay a 1.5% per month late charge on all accounts over thirty (30) days past due. The Patient and the Responsible Party recognize and agree that their obligations to make payment are joint and severable and that they, and not any insurance company, are solely responsible for the entire bill, even though the cost of the medical care may exceed the amount reimbursed by the third-party insurers or payors.

The Patient and the Responsible Party hereby acknowledge, understand, and agree that it is difficult to project the full cost of medical services and treatments in advance, since it is impossible to know what services, tests, procedures, and/or treatments will be required in the course of medical care.

The Patient and the Responsible Party hereby agree to be fully responsible for any and all amounts and charges submitted by the Physicians in the course of treatment or any of their agents, employees, or contractors, which shall include, but shall not be limited to, the amounts set forth on the fee schedule attached hereto or kept at the front desk by Hearts South, P.C., (which I[we] acknowledge is available to me [us]). The Patient and the Responsible Party acknowledge that the charges may exceed the amount Blue Cross or another insurance carrier may define as "usual and customary, or reasonable", but the Patient and Responsible Party agree to pay the amount of such billed charges.

I, the undersigned, understand and agree to the above information.

DATE: _____ _____

PATIENT

DATE: _____ _____

RESPONSIBLE PARTY

Hearts South, PC
Specialists in Cardiovascular Care

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Donna L. Trimnel, Administrator

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Marla Hodge, CRNP, FNP-BC

Authorization for Request of Protected Health Information (PHI)

Please release to:
Hearts South, PC
1118 Ross Clark Circle Suite 403
Dothan, AL 36301

I authorize the release of my protected health information:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Social Security Number: _____

The type and amount of information requested is as follows:
☐Complete Medical Record ☐Medical Discharge Summary ☐History and Physical
☐Nursing Summary ☐Operative Notes
☐Lab Report (Specify) _____ ☐Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from date signed.

I understand that I may inspect or copy the information to be used or disclosed, as provided in Notice of Privacy Practices. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information or to present my written revocation authorization I can contact: Donna Trimnel, Administrator 1118 Ross Clark Circle Suite 403 Dothan, AL 36301.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient (if applicable)

_____
Witness

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Notice of Privacy Practices Summary

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact our Privacy Office who is: Donna Trimnel, Administrator, (334) 793-5672.

This is a summary of our Notice of Privacy Practices, which describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations (TPO).

Other uses and disclosures of your protected health information (PHI) will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request a restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information. Charges to receive copies of your protected health information will be in accordance with practice policy which is in accordance with state and federal law.

You have the right to request to amend your protected health information. We also have the right to comment and respond to any amendments that you make to your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
This summary was published as supplement to our Notice of Privacy Practices.

As a patient of our practice, you have the right to a copy of our Notice of Privacy Practices, if you request one. We have the policy posted in our office waiting room for your reference.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I, _____, ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM HEARTS SOUTH, PC.

_____ _____
Signature of Patient or Personal Representative — Printed Name of Patient or Representative

_____ _____
Date — Relationship to Patient or Authority to Serve

DOCUMENTATION OR REASON(S) PATIENT REFUSED TO SIGN: _____

_____

_____

WITNESS _____ DATE _____

Revised 7/31/09 - FORM-PPS.sum.-4/14/03-#1

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer who is:
Donna L. Trimnel, Administrator, (334) 793-5672

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time. Upon your written request, we will provide you with any revised Notice of Privacy Practices. You may also call the office and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment.

Uses and disclosures of protected health information for treatment, payment and health care operations

We will use your protected health information as part of rendering patient care, including treatment, payment and health care operations. The following are some, but not all, examples of the types of uses and disclosures that may be made by us.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information also may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure or your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures or your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke an authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Permitted uses and disclosures of protected health information that may require an objection

We may use or disclose your protected health information in the following situations unless you object to the use and/or disclosure. These situations include:

Limited use or disclosure when you are not present: If you are not present or able to agree or object to the use or disclosure of the protected health information because of incapacity or emergency circumstances, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on your physician's professional judgment.

Notification: Unless you object, we may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death.

Disaster relief: Unless you object, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation if, in your physician's professional judgment, the use or disclosure is in your best interest. If so, we will disclose only the protected health information that is directly relevant to the person's involvement with your health care.

Other permitted and required uses and disclosures that may be made without your authorization or opportunity to object

We may use or disclose your protected health information in the following situations without your authorization or opportunity to agree or object. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that such use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may use or disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made in accordance with state law for the purpose of preventing or controlling disease, injury or disability. It may include, but is not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information under law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to comply with requirements or at the direction of the Food and Drug Administration to report adverse events; product defects or problems; biologic product deviations; track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order or a court of administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes and otherwise required by law. (2) limited information request for identification and location purposes: (3) pertaining to victims of a crime: (4) suspicion that death has occurred as a result of criminal conduct (5) in the event that a crime occurs on the premises of the practice; and (6) a medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Medical Examiners, and Funeral Directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death.

Organ, eye or tissue donation: Protected health information may be used and disclosed to organ procurement organizations or other entities involved in the procurement, banking or transplantation for cadaver organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Serious threat to health or safety: Consistent with applicable laws and standards of ethical conduct, we may use or disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of person or the public and to a person(s) reasonably able to prevent or lessen the threat. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities: (2) for separation or discharge from military service (3) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits; or (4) to foreign military authority if you are a member of that foreign military service.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related injuries or illness without regard to fault.

Communicable Diseases: We may disclose your protected health information, according to state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members, friends or any other person who may be involved in your care or for notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you request. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by placing the request in writing and discussing it with your physician.

You have the right to receive communications concerning your protected health information in a confidential manner. We will accommodate reasonable requests by you to receive communications of protected health information by an alternative means or at

alternative locations. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Any request of this nature must be made in writing.

You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of protected health information about you that is contained in a "designated record set" for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records about you that your physician and the practice uses for making decisions about you.

This right is subject to certain specific exceptions. For example, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; protected health information created and maintained by another physician, hospital, or other provider of service; and protected health information that is subject to law that prohibits access to such protected health information. If we deny your access to your protected health information, we will provide you with a reason for the basis of the denial. In some instances, a tight to have a decision to deny access can be reviewed. You may be charged a reasonable fee for any copies of your records as allowed under the state law. These charges will be as follows: $5.00 retrieval fee, $1.00 per page for the first 25 pages and $.50 for each page thereafter. Payment will have to be made prior to you receiving a copy of your records. Contact our privacy office if you have any questions about inspecting and copying your protected health information.

You have the right to amend protected health information. You may request an amendment, in writing, of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our privacy officer if you have questions about amending your protected health information.

You have a right to receive an accounting of disclosures we have made of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, those that were authorized by your or your personal representative, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures during the last six years prior to the date of your request. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to only read this notice.

Complaints

You may file a complaint to us or directly to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint in writing. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Donna L. Trimnel, Administrator, 334-793-5672 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

Revised 7/31/09

Form-Pri.Pract.-4/14/03-#1

Hearts South, PC

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Patient History

Patient Name: _____ Date of Birth: _____

Appointment is _____@_____ Referring Physician: _____

Reason for Referral: _____

PLEASE READ ALL OF THE INFORMATION BELOW AND FILL IN ALL BLANKS WITH AS MUCH INFORMATION AS POSSIBLE (DATES, AGES, ETC.).

Cardiac Risk Factors: (Please check YES or NO)

Have YOU, the patient, ever had any of the following:

Stroke/Mini-Strokes/TIA?	☐YES	☐NO	When? _____
Neck Artery Blockage?	☐YES	☐NO	When? _____
Leg Artery Blockage?	☐YES	☐NO	When? _____
Diabetes?	☐YES	☐NO	When? _____
High Blood Pressure?	☐YES	☐NO	When? _____
High cholesterol?	☐YES	☐NO	When? _____
Family History of Heart Disease? (Before the age of 60)	☐YES	☐NO	Who? _____

_____

Use TOBACCO? ☐YES ☐NO / Never ☐No, I quit

What type? ☐Cigarettes ☐Cigars ☐Dip ☐Chew ☐ All Types

How much per day? _____ How many years? _____ When did you quit? _____

FEMALES ONLY:

Completed/going through Menopause?	☐YES	☐NO	When? _____
Partial OR Complete Hysterectomy?	☐YES	☐NO	When? _____
Hormone Replacement Therapy?	☐YES	☐NO	When? _____

Cardiac/Vascular History: (Please check YES or NO and give details: when, where, etc.)

Have YOU, the patient, had any of the following:

Documented rhythm problems?	☐YES	☐NO	_____
EKG (electrocardiogram)?	☐YES	☐NO	_____
Holter Monitor (24 hours or 30 Days)?	☐YES	☐NO	_____
Stress Testing (Nuclear or Regular)?	☐YES	☐NO	_____
Echocardiogram (Ultrasound of Heart)?	☐YES	☐NO	_____
Cardiac CT Scan?	☐YES	☐NO	_____
Heart Catheterization?	☐YES	☐NO	_____
Angioplasty (Balloon)/Stent Placement?	☐YES	☐NO	_____
Heart Surgeries (Bypass/Valve Replacement/Pacemaker/AICD Implant)?	☐YES	☐NO (Circle all the apply)	
Heart Attack?	☐YES	☐NO	
Carotid Ultrasound?	☐YES	☐NO	_____
Carotid Endarterectomy? (Left or Right)	☐YES	☐NO	_____
CT Scan / MRA?	☐YES	☐NO	_____
Non-invasive vascular testing?	☐YES	☐NO	_____
Arteriogram/ stent of legs or neck?	☐YES	☐NO	_____
Bypass surgery of leg arteries?	☐YES	☐NO	_____

******* In order to avoid delays, please obtain your records BEFORE your appointment. This is your responsibility. *******

Doctors Building, Suite 403 · 1118 Ross Clark Circle · Dothan, Alabama 36301

(334) 793-5672 · 1-800-293-5672 · FAX: (334) 794-0378

Medical History: **(Please circle any problem that YOU, the patient may have/had)**

Anemia Anxiety Asthma Bladder Problems Bleeding Diathesis Cancer (type) _____

Carpal Tunnel Syndrome Colon Polyps Depression DVT (blood clot in leg) Dialysis Fibromyalgia

Gallbladder Problems Gastroesophageal Reflux Gastrointestinal Disease Glaucoma Gout Liver Problems Kidney

Stones Obstructive Sleep Apnea / CPAP Osteoarthritis Other: _____ Psychiatric Disorder Lung Problems

PTE (blood clot in lungs) Kidney Problems Rheumatic Fever Rheumatoid Arthritis Scarlet Fever Scoliosis

Thyroid Disease Tuberculosis ☐**NONE**

Surgical History: **(Please include approximate dates)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Most recent Influenza Vaccination/Pneumonia – When/Where? _____

Allergies: **(Please check Yes or No and what type of reaction did you have?)**

Shellfish	☐YES	☐NO	_____
Iodine	☐YES	☐NO	_____
IVP Dye	☐YES	☐NO	_____
Latex	☐YES	☐NO	_____
Food	☐YES	☐NO	_____
			_____
Drugs	☐YES	☐NO	_____
			_____
			_____

Current Pharmacy? _____

Current Medications:

Please include all Insulin, over the counter medications/vitamins/herbs and their strengths and how often you take each of them.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History: **(Please fill out all areas COMPLETELY)**

Relative	AGE(s)			Explanation
Father	_____	☐Living	☐Deceased	_____
Mother	_____	☐Living	☐Deceased	_____
Brother(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
Sister(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
Daughter(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____
Son(s)	_____	☐Living	☐Deceased	_____
	_____	☐Living	☐Deceased	_____

Social History: **(Please check all that apply)**

Are YOU, the patient?

☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

☐Live alone ☐Live with Family / Friend / Other Number of People in house is _____

In School - Where?_____

Working - Where & Type? _____ How long? _____

Retired - From? _____ How long? _____

Disabled - Why? _____ How long? _____

Do YOU, the patient:

Use ILLEGAL DRUGS ☐YES ☐NO, Never ☐NO, I quit What type? _____

How often? ☐Daily ☐Weekly ☐Monthly ☐Socially ☐Rarely

How many years? _____ When did you quit?_____

Use ALCOHOL ☐YES ☐NO, Never ☐NO, I quit

What type? ☐Beer ☐Wine ☐Whiskey ☐ALL TYPES

How often? ☐Daily ☐Weekly ☐Monthly ☐Socially ☐Rarely

How many years? _____ When did you quit?_____

Intake CAFFEINE? ☐YES ☐NO, Never ☐NO, I quit

TYPE: Coffee - how much? _____ Tea - how much? _____

Soda - how much? _____ Chocolate - how much? _____

ADVANCED DIRECTIVE:

Living Will ☐YES ☐NO _____

Organ Donor ☐YES ☐NO _____

SYMPTOMS:

Please circle ALL that apply OR check NONE of the above.

Constitutional: Fatigue, fever, chills, weight change, headaches, loss of appetite, night sweats, abnormal activity level. ☐**NONE**

Head, Eyes, Ears, Nose, Mouth, Throat: Head pain, dizziness, dry eyes, conjunctivitis, cataracts, double vision, blurred vision, glasses, vision loss, hearing loss, ear pain, ringing in ears, sinusitis, nasal obstruction/ discharge, nose bleeds, ear drainage, snoring, sore throat or mouth sores, hoarseness, trouble swallowing, tooth/gum trouble, dry mouth, wears dentures, swollen lymph nodes. ☐**NONE**

Cardiovascular: Chest pain, shortness of breath, shortness of breath when lying down, edema, palpitations, murmurs, passing out, nearly passing out, high blood pressure, bluish fingers/toes. ☐**NONE**

Respiratory: Asthma, coughing, wheezing, coughing up sputum, night-time shortness of breath, fast breathing, coughing up blood ☐**NONE**

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, laxative use, hemorrhoids, bloody stool, abdominal pain, food intolerance, abnormal stool, change in bowel habits, vomiting blood, jaundice or Hepatitis, black stool, use of antacids, anorexia ☐**NONE**

Musculoskeletal: Back pain, muscle weakness, stiffness, neck pain, muscle pain, cramps, Loss of motion joint pain/swelling/inflammation. ☐**NONE**

Neurological: Paralysis or weakness, numbness, seizure activity, tremors, dizziness, head trauma, syncope, vertigo, headache, local weakness, tingling, memory loss, neuropathy. ☐**NONE**

Integumentary: Acne, birth marks, body piercing, dryness, eczema, overgrowth of hair, itching, loss of hair, lumps, nail biting, scalp flaking and itching, skin rashes, skin cancer, tattoos, scars. ☐**NONE**

Psychiatric: Anxiety, depression, suicidal thoughts or attempts. ☐**NONE**

Endocrine: Diabetes, goiter or thyroid disease, excessive urination, sleep disturbance, weight gain or loss, excessive thirst, heat or cold intolerance, increased appetite, excessive sweating. ☐**NONE**

Hematologic/Lymphatic: Abnormal bleeding, anemia, bruising, swelling of lymph gland, nose bleeds, past transfusions. ☐**NONE**

Female Genitourinary: Abnormal menses, vaginal discharge, change in sexual activity, pregnancy, blood in the urine, Chlamydia, frequency, painful urination, intermenstrual bleeding, vaginal itching, Condyloma, Herpes, Gonorrhea, painful menstrual cycle, pelvic pain, excessive urination, dribbling. ☐**NONE**

Male Genitourinary: Change in sexual activity (erectile dysfunction), testicular pain/swelling, painful urination, urethral discharge, circumcision problems, blood in urine, incontinent of urine, increased frequency, increased urination, dribbling, Condyloma, herpes, syphilis, gonorrhea. ☐**NONE**

I certify that this information is true and complete to the best of my knowledge.

_____	_____	_____
Patient's Signature	Preparer's Signature	Date
_____	_____	
Hearts South Personnel	Date	