Adult Medical History Form

Direct Primary Care OF FLORIDA

Legal Name: _____ DOB: _____ Date: _____

Preferred Name (if different than above): _____

Marital Status: S M W D Partner

Occupation: _____
If retired, previous occupation: _____

Household (who lives in your household?)

List allergies/intolerances to medications (and the reaction they cause):

Personal Medical History: Circle Yes or No, explain yes answers (when occurred or was diagnosed)

Alcoholism	Y	N
Anxiety Disorder	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Bleeding tendency	Y	N
Blood clot	Y	N
Cholesterol (high)	Y	N
Cancer	Y	N
Depression	Y	N
Diabetes	Y	N
Emphysema/COPD	Y	N
Epilepsy	Y	N
Exposure to asbestos	Y	N
Exposure to TB	Y	N
Glaucoma	Y	N
Hayfever	Y	N
Heart disease	Y	N
Hepatitis (yellow jaundice)	Y	N
High blood pressure	Y	N
Kidney disease	Y	N
Kidney stone	Y	N
Migraines	Y	N
Osteoporosis	Y	N
Pneumonia	Y	N
Polio	Y	N
Recurrent bladder infection	Y	N
Rheumatic fever	Y	N
Sleep Apnea	Y	N
Stroke	Y	N
Thyroid disease	Y	N
Tuberculosis	Y	N
Ulcer	Y	N
Other serious illness	Y	N

Please list all operations, including year performed:

Family History (Blood Relatives)

	Age at Death	If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brothers and Sisters		
1		
2		
3		
4		
5		
Children		
1		
2		
3		
4		
(Females) Number of pregnancies:		
Number of births:		

Health Maintenance (answer applicable questions)

When was last pap smear?

When was last mammogram?

Have you had a bone density test? Y ○ N ○ If yes, when?

Have you had a colonoscopy? Y ○ N ○ If yes, when?

Do you have a Living Will/Advanced Directives? Y ○ N ○

Immunizations

When was last tetanus vaccine?

Have you had a pneumonia vaccine? Y ○ N ○ If yes, when?

Safety/Social Habits (please circle answers)			
Do you use alcohol?	○ Y	○ N	○ Past
If so, how much per day?			
Do you use tobacco?	○ Y	○ N	○ Past
If yes, how much per day?			
If in past, when did you quit?			
Are you exposed to secondhand smoke in your home?	○ Y	○ N	○ Past
Do you use caffeine, coffee, tea, soda? (circle one)			
If so, how much per day?			
Do you use "recreational drugs"?	○ Y	○ N	○ Past
If yes, what do you use?			
Are you sexually active?	○ Y	○ N	
If so, with whom?	○ males	○ females	○ both
What do you do for exercise?			
How often do you exercise?			
Have you ever been abused?	physically	mentally	sexually

Are you satisfied with your weight?	○ Y	○ N
Do you always wear a seatbelt?	○ Y	○ N
If you ride a bike or motorcycle, do you always wear a helmet?	○ Y	○ N
Are guns kept in your home?	○ Y	○ N
If yes, is household aware of gun safety?	○ Y	○ N

FORM CONTINUES ON THE OTHER SIDE

Review of Systems

Direct Primary Care OF FLORIDA

Do you **now have**, or have you **recently had** problems related to the following systems? Circle Yes or No. Please explain any Yes answers in the space provided.

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight loss/gain	Y	N
Other:	Y	N
Ear/Nose/Throat/Mouth		
Ear symptoms	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other:	Y	N
Hematologic/Lymphatic		
Swollen glands	Y	N
Easy bruising	Y	N
Other:	Y	N
Cardiac		
Chest Pains	Y	N
Irregular heartbeats	Y	N
Other:	Y	N
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other:	Y	N
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Black or bloody stools	Y	N
Diarrhea	Y	N
Other:	Y	N

Genitourinary		
Painful urination	Y	N
Urinary incontinence	Y	N
Blood in urine	Y	N
Other:	Y	N
Dermatologic		
Skin rash	Y	N
Mole change	Y	N
Other:	Y	N
Gynecologic		
Pelvic pain	Y	N
Irregular periods	Y	N
Painful periods	Y	N
Vaginal discharge	Y	N
Other:	Y	N
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other:	Y	N
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other:	Y	N
Psychologic		
Do you have depressed feelings?	Y	N
Have you considered suicide?	Y	N
Sleep disturbance?	Y	N
Other:	Y	N

What do you do for fun?

Physician Use Only: (comments/notes)

Physician: _____ Date: _____

Authorization to Release Medical Information

Direct Primary Care OF FLORIDA

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B _____
Street, City, State, Zip

Home Phone _____ Work Phone _____ S.S.# _____

I Authorize Information Released FROM: (Please Print)	**Please Send My Records TO:** (Please Print)
Name _____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____

Purpose of Release

☐ Dissatisfied with practitioner ☐ Moving ☐ Referral/Consultation

☐ Dissatisfied with staff ☐ Personal use ☐ Legal

☐ Transfer of care ☐ Insurance change ☐ Other _____

Permission to Fax Information: I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

I would like records sent via: ☐ CD (Adobe 8 or higher) ☐ Paper (***If not checked, CD is the default method.)***

Type of Information To Be Released

☐ General Medical Records (Consists of the last two years of treatment)

☐ **Specific Information Only**: please specify _____

Protected or Sensitive Information: I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALING** I authorize the release of the following protected or sensitive information:

_____ Initial Drug/Alcohol Diagnosis/Treatment/Referral Information

_____ Initial Genetic Testing Information

_____ Initial Mental Health/Treatment

_____ Initial HIV/AIDS Information

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment.

You have the right to revoke this authorization at any time, provided that you do so in writing to Northwest Primary Care Group. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

This authorization will expire in 180 days from the date of signing, or unless otherwise specified _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

BY: _____ DATE: _____
Patient or Patient Representative

Description of Representative's Authority: _____

Direct Primary Care
OF FLORIDA

Instructions for completing NWPC Record Release Form:

(Important: any missing or inaccurate entries may delay or void your request)

- Photo ID may be required for patient/guardian verification
- Be sure to write legibly, to include:
  - Birthdate
  - Previous name (if any)
  - Where would you like the records sent (include address or fax number)
  - Why the records are being sent (purpose of release)
  - Type of information to be released (standard for “all records” is last two years of treatment unless specifically requested otherwise).
  - Patient/guardian signature and date
- If you want the information to be faxed, please mark on the form, “Permission to Fax”. Please note that we will not fax any records that are more than 50 pages.
- Please allow 30 days for records to be sent as per Oregon State Law.

Who can receive copies of medical records:

Adult patients - Copies of their own medical records

Parent or Legal Guardian - Copies of their minor child’s medical records

Legal Power of Attorney - Copies of the medical records of the person named in the power of attorney (for example; wife, husband or partner, disabled adult)