STAT Health

PATIENT HISTORY & PHYSICAL

This form is completely confidential and will be part of your medical record.

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Date:_____

Is today's visit related to a motor vehicle accident? ☐Yes ☐No Is this a work related injury? ☐Yes ☐No

Reason for Today's Visit:_____

Patient Name_____

Date of Birth_____ Sex_____

Address_____

City_____State_____ Zip_____

Home Phone_____

Cell Phone_____

Email_____

PHARMACY

Name_____

Address/City_____

Primary Insurance Name_____

Policy Holder Name_____

Policy Holder Address_____

City_____State_____Zip_____

Secondary Insurance Name_____

Policy Holder Name_____

Relationship to Insured ☐Self ☐Spouse ☐Child ☐Other

Mother's Name/Guardian(if under age 21)_____

Father's Name/Guardian(if under age 21)_____

Race: ☐White ☐Black/African American ☐Hawaiian/Pacific Islander ☐American Indian ☐Asian ☐Declined/Unknown ☐Other_____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Other_____ **Preferred Language:**_____

How did you hear about us? ☐Walked/Drove By ☐Google Search ☐Friend/Family Referral ☐Community Event ☐Social Media ☐Facebook ☐Yelp ☐Postcard/Mailer ☐Online Ad/Listing ☐Radio/TV ☐Newspaper/Magazine

What is your preferred method of contact? ☐Phone ☐Text ☐Email

Primary Care Physician(PCP) Name_____Town:_____

Would you like a copy of todays visit summary sent to your PCP? ☐Yes ☐No Referred Specialist? ☐Yes ☐No

Name of person filling out this form if not patient_____

PATIENT HIPAA AWARENESS

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except stated in the Notice of Privacy Practice, or in accordance with your wishes as stated below. This waiver authorizes STAT Health Immediate Medical Care, P.C. to send/release medical information as noted:

1. ☐Yes ☐No Leave a voicemail recording including my Personal Health Information on my home/cell phone

2. ☐Yes ☐No Speak to an individual of my choosing (Personal Representative) regarding a medical emergency, my Personal Health and Billing information, and permit him/her to receive prescriptions and/or test results on my behalf

Name of Personal Representative _____

Relationship_____

Date of Birth of Representative_____

Phone Number_____Email Address_____

On this date_____, I received/reviewed STAT Health Immediate Medical Care, P.C.'s Notice of Privacy Practices, which describe how my medical information may be used and disclosed, and explains how I can get access to this information.

The authorizations made above will remain in effect until I notify STAT Health Immediate Medical Care, P.C. in writing, by certified mail, of requested changes.

Signature of Patient or Legal Guardian_____Date:_____

Print Name of Patient or Legal Guardian_____

MEDICATIONS

LIST ALL MEDICATIONS *YOU* ***CURRENTLY*** TAKE
(Including Non-Prescription Medications And Herbal Remedies)

Medication Name	Dose	Times Daily

ALLERGIES: Please list all

1. **Medication(s)**_____

_____

2. **Food**_____

3. **LATEX ALLERGY** ☐ Yes ☐ No

FAMILY HISTORY Check all that apply

Present Health or Cause of Death	Present Age *or* Age At Death		Relationship
			☐ Adopted ☐ Unknown
Bleeding Disorder			☐ Father ☐ Mother ☐ Brother ☐ Sister
Clotting Disorder			☐ Father ☐ Mother ☐ Brother ☐ Sister
Diabetes			☐ Father ☐ Mother ☐ Brother ☐ Sister
Stroke			☐ Father ☐ Mother ☐ Brother ☐ Sister
Heart Disease			☐ Father ☐ Mother ☐ Brother ☐ Sister
Hypertension			☐ Father ☐ Mother ☐ Brother ☐ Sister
Cancer:_____			☐ Father ☐ Mother ☐ Brother ☐ Sister

MEDICAL HISTORY

Answer these history questions by checking the appropriate boxes.
HAVE YOU *EVER* HAD:

☐ Heart Condition ☐ High Blood Pressure ☐ Stroke
☐ Asthma ☐ COPD ☐ Emphysema
☐ Gall Bladder Problems ☐ Ulcer
☐ Jaundice ☐ Hepatitis ☐ Liver Disease
☐ Ulcerative Colitis ☐ Crohn's Disease ☐ IBS
☐ Kidney Problems ☐ Bladder Problems
☐ Sexually Transmitted Disease(s)
☐ HIV
☐ Arthritis ☐ Chronic Pain
☐ Frequent Headaches ☐ Migraines
☐ Seizure Disorder
☐ Depression ☐ Anxiety ☐ Mental Illness
☐ Hyperthyroid ☐ Hypothyroid
☐ Diabetes: ☐ Insulin ☐ No Insulin
☐ Skin Diseases: Specify_____
☐ Breast Problems ☐ Prostate Problems
☐ Anemia ☐ Clotting Disorder ☐ Blood Clot
☐ Blood Transfusion: Date of Last Transfusion_____
☐ Birth Defects ☐ Inherited Diseases
☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox
☐ Organ Transplant_____
☐ Cancer: Type_____
☐ Other Medical Problem(s)_____
☐ No Known Medical Problems

SOCIAL HISTORY

Do you smoke? ☐ Never ☐ Former ☐ Current ☐ Social
_____#/Day _____#Years When Quit_____

Consume Alcohol? ☐ Never ☐ Occasionally ☐ Heavily
_____Drinks/Week When Quit_____

Drug Use? ☐ Never ☐ Former ☐ Current
Type(s):_____

Are you on Oxygen? ☐ Yes ☐ No

LIST YEAR YOU RECEIVED THE FOLLOWING VACCINES

_____Flu Vaccine _____Hepatitis B
_____Tetanus _____T.B.Test(PPD)
_____Pneumonia _____Shingles

ASSISTIVE DEVICES

Glasses: ☐ Yes ☐ No
Contact Lenses: ☐ Yes ☐ No
Hearing Aids: ☐ Yes ☐ No
Ambulate: ☐ Cane ☐ Walker ☐ Wheel Chair

FOR WOMEN ONLY

Date of Last Menstrual Period_____

Have you ever taken Birth Control Pills?
☐ Yes ☐ No How Long?_____Yrs.

Are you currently taking any form of oral or implanted Birth Control?
☐ Yes ☐ No Type:_____

Are you currently taking hormone replacements?
☐ Yes ☐ No Type:_____

HOSPITALIZATIONS: Please list any operations or serious illnesses that you have had which required hospitalization. If you have had more than four, check this box ☐
Do not include pregnancies here.

Mo./Yr.	Illness or Operation	Complications Yes	Complications No
		☐	☐
		☐	☐
		☐	☐

PRIOR CANCER TREATMENT

Mo./Yr.	Radiation Site	Chemo Type