CLINIC PERSONAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

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

Gender: ☐ Male ☐ Female

ALLERGIES TO MEDICATIONS (include reaction type/sign/symptoms)

1.	4.
2.	5.
3.	6.

CARE TEAM

Person, Provider, Specialist, Care Giver, DME Company, etc.	Specialty / Relation	Phone Number

MEDICAL PROBLEMS

Acid Reflux	Diverticulitis / Diverticulosis	Pancreatitis
ADD / ADHD	Eczema / Psoriasis	Parkinson Disease
ALS	Emphysema	Pelvic Inflammatory Disease
Alzheimer's	Fibromyalgia	Peripheral Artery Disease
Anemia	Gastrointestinal Bleed	Phlebitis
Aneurysm	Glaucoma	Pneumonia
Anxiety Disorder	Goiter	Polio
Asthma	Gout	Restless Leg Syndrome
Atrial Fibrillation	Head Trauma	Retinopathy
Autoimmune Disorder	Heart Attack	Rheumatic Fever
Bipolar Disorder	Heart Disease / Heart Failure	Rubella
BPH (enlarged prostate)	Heart Valve Disorder / Murmur	Schizophrenia
Bladder Problem(s)	Hepatitis A / B / C / Other	Sciatica
Blood Clot(s)	High Blood Pressure	Seizure Disorder
Blood Disorder(s)	High Cholesterol	Sexually Transmitted Disease
Cancer _____	Irritable Bowel Syndrome	Sleep Apnea
Carotid Stenosis	Kidney Problem(s)	Stomach Ulcer(s)
Chicken Pox	Lupus	Stroke / TIA
Chronic Pain	Measles	Thyroid Problem(s)
Colon Polyp(s)	Migraine Headaches	Tuberculosis
COPD	Multiple Sclerosis	Ulcerative Colitis
Dementia	Mumps	Vertigo
Depression	Neuropathy	Vitamin B12 Deficiency
Diabetes	Osteopenia / Osteoporosis	Vitamin D Deficiency

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED THAT ARE NOT LISTED ABOVE

Please turn to the next page

CLINIC PERSONAL HEALTH HISTORY

SOCIAL HISTORY

Marital status	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	
	Do you live alone? ☐ Yes ☐ No	If no? ☐ With Family	☐ With Spouse	☐ Other			
Employment	☐ FullTime	☐ PartTime	☐ Homemaker	☐ Retired	☐ Disabled	☐ Student	☐ Other
	Current Occupation:						
	Past Occupation:						
Advanced Care Planning	Do you have an Advance Directive and/or Living Will? ☐ Yes ☐ No						
	If yes, where is it kept?						
	If no, would you like information on Advance Directives? ☐ Yes ☐ No						

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire will be kept strictly confidential.

Alcohol	Do you drink alcohol? ☐ Yes ☐ No		
	What kind?	How much?	How often?
Drug Use	Do you currently use recreational or street drugs ☐ Yes ☐ No		
	What kind?	How much?	How often?
Exercise	☐ No routine/regular exercise		
	☐ Routine/regular exercise		
	What kind?	How much?	How often?
Tobacco Use	Do you currently, or have you ever used tobacco products? ☐ Yes ☐ No		
	☐ Current Tobacco User	☐ Former Tobacco User	
	What kind of tobacco?	How much?	How Often?
	Start date / age / year:	Quit date / age / year:	

FAMILY MEDICAL HISTORY

Adopted: ☐ Yes ☐ No

Relation	Cancer *List Type*	Alzheimer's and/or Dementia	Heart Disease and/or High Blood Pressure	Heart Attack and/or Stroke	Diabetes	Autoimmune Disease *List Type*	Vascular or Arterial Disease (CAD, CVD, PVD, PAD, etc.)	Asthma, CHF, other Lung Disease
Mother								
Father								
Brother 1								
Brother 2								
Sister 1								
Sister 2								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								

LIST ANY SIGNIFICANT HEALTH PROBLEMS THAT ARE NOT LISTED ABOVE

SURGICAL HISTORY

Date / Age	Surgery (example: left knee replacement)	Date / Age	Surgery (example: gallbladder removed)

Please turn to the next page

CLINIC PERSONAL HEALTH HISTORY

IMMUNIZATION HISTORY – IF A "BLUE CARD" OR CHILDHOOD IMMUNIZATION HISTORY IS AVAILABLE PLESE PROVIDE A COPY			
Hepatitis A	Completed	Pneumococcal Polysaccharide (PPSV23)	Date
Hepatitis B	Completed	Tetanus, Diphtheria, Pertussis (Tdap)	Date
HPV (2, 4, or 9)	Completed	Tetanus, Diphtheria) Td	Date
Influenza (Flu Vaccine)	Date:	Varicella (Chickenpox)	Completed
Measles/Mumps/Rubella (MMR)	Completed	Zoster Live (Zostavax)	Date
Meningococcal (meningitis)	Completed	Zoster Recombinant (Shingrix)	Completed
Pneumococcal Conjugate (PCV13)	Date	Other:	

PREVIOUSLY PERFORMED TESTS AND SCREENINGS			
Colonoscopy	Date	Pap Smear with HPV	Date
Cologuard	Date	GYN Check Up	Date
DEXA – Bone Density	Date	PSA	Date
Dilated Eye Exam	Date	Hemoglobin A1c	Date
Fecal Occult Blood (stool card)	Date	TB Skin Test	Date
Lipid / Cholesterol Level	Date	Other:	Date
Mammogram	Date	Other:	Date

CURRENT MEDICATIONS

Prescriptions, Over the counter, Vitamins, Supplements, Injections, Birth Control Implants, Chemotherapy, etc.

Medication Name	Strength	Frequency Taken

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Location	Pharmacy Phone Number

RECEIPT FOR HIPAA PRIVACY NOTICE AND AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION (MW119)

Patient Name _____ Date of Birth _____

Social Security Number _____ Preferred Phone Number _____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that **I may revoke this authorization at any time by notifying Medical West** in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise. I hereby authorize Medical West to disclose health information to the following:

Name & Relation _____ Phone # _____

Name & Relation _____ Phone # _____

Name & Relation _____ Phone # _____

Name & Relation _____ Phone # _____

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MEDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

☐ Yes ☐ No The physicians and staff of Medical West may confirm my appointment to my voice mail / answering machine at the number provided on my patient information sheet.

☐ Yes ☐ No The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my voice mail / answering machine.

☐ Yes ☐ No The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions _____

My signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Printed Name of Patient or Authorized Representative _____

Relationship _____ Patient Signature or Authorized Representative _____ Date/Time

CONSENT FOR TREATMENT

Consent for Healthcare Services:
I hereby authorize the provider(s) or clinic staff to provide maintenance, care, tests, diagnostic procedures, x-rays, medical and surgical treatments as may be necessary for the preservation or protection of my/the patient's health, safety and well-being. I understand that no guarantees have been given as to the effectiveness or outcome of any treatment or procedure rendered. I intelligently, voluntarily and freely give my consent or warrant that I am legally authorized to give consent on behalf of the patient.

Authorization to Release Information:
I authorize the provider(s) and/or clinic staff to release medical records, related medical information and charge information for my/the patient's outpatient/clinic visit for further medical treatment and determining insurance coverage and medical payment owed for clinic/hospital charges, including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, or welfare funds. I certify that the information given by me/the patient in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical information given by me/the patient to release to the Social Security Act is correct. I authorize any holder of medical information given by me/the patient to release to the Social Security Administration or its intermediaries or the Medicaid agency or its intermediaries any information needed for Medicare or Medicaid claim. I consent to the release of information including psychiatric, drug, alcohol and substance abuse records, except for psychotherapy notes which require specific written authorization by me/the patient/patient's legal guardian. I consent to the release of information to any specialist in the event of a referral from the provider(s).

Assignment of Benefits (if covered by insurance):
I direct that my/the patient's insurance company pay the benefits for this treatment directly to the clinic. I assign to the clinic/hospital for security, any right I/the patient may have to receive such payment directly from the insurance company, and hereby revoke any prior authorization which I/the patient may have given to the contrary. I agree to cooperate fully with the clinic's efforts to obtain payment under such policy and will execute any additional documents my/the patient's insurance company may require to process the clinic's claim. In the event of overpayment of insurance benefits, (as where two policies are subject to a coordination of benefits). I authorize the clinic to refund to the company making such overpayment.

Estimate of Charges:
As a hospital-based outpatient health center, it is possible that patients' co-payments may vary for certain outpatient services and procedures. Medicare requires we provide patients an estimate of Facility Fee and Health Care Professional Fee co-payment amounts. The average patient out-of-pocket expense ranges from $0-$50.00. We recommend that patients review their insurance benefits to determine what their policy will pay and what out-of-pocket expenses may be incurred.

Financial Responsibility:
I understand that by signing below, I AGREE TO PAY THE CLINIC BILL for services rendered. I agree that I will pay this bill in full whether charges are or should have been covered by insurance. I have been advised that the clinic does not extend credit, and that any copayment or established self-pay rate is due in full at the time of service. I agree that if this account is not paid when due, and if the clinic should refer it to an attorney for collection, I will pay all costs of collection including interest, and a reasonable attorney's fee (even if suit is not filed), and reasonable collection agency fees. Acknowledgement of Notice of Health Information Practices

☐ I/the patient have/has received a copy of the Medical West an affiliate of the UAB HEALTH SYSTEM's **Notice of Health Information Practices.** These practices have been explained to me. All questions concerning this notice have been addressed to my satisfaction.

Relationship

Printed Name of Patient or Authorized Representative

Patient Signature or Authorized Representative

Date/Time

UAB MEDICAL WEST

CLIPTINFO

1070
12/2022

CLINIC PATIENT INFORMATION

Patient Information

Today's Date: _____

Full Name: _____ (Last) _____ (First) _____ (M.I) Date of Birth: _____

Address: _____ (Street Address) _____ (Apartment/Unit #)

_____ (City) _____ (State) _____ (ZIP Code)

Home #: _____ Cell #: _____ Email: _____

SS #: _____ Race: _____

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced Gender: ◯ Male ◯ Female

Employment

Employer: _____ Dept/Title: _____

Address: _____ (Street Address) _____ (Phone #)

Emergency Contact

Spouse/Companion/Guardian:

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Nearest relative or friend not living with you:

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group#: _____

Name of Insured: _____ Relationship: _____

SS#: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____ Group#: _____

Name of Insured: _____ Relationship: _____

SS#: _____ DOB: _____

Worker's Compensation ◯ YES ◯ NO

Contact Person: _____ Title: _____ Phone: _____

Billing Information

Person Responsible for Payment

Full Name: _____ Relationship: _____ SS#: _____

Address: _____ (Street Address) Phone # _____

Employer: _____ Dept/Title: _____

Address: _____ (Street Address) Phone # _____

Referral Information

Referred by: _____ Phone: _____

MEDICAL WEST
an affiliate of the UAB HEALTH SYSTEM

Pulmonary Health Center
985 9th Ave SW, Suite 306
Bessemer, AL 35022
Phone: (205) 481-7058

NO SHOW/CANCELLATION POLICY FOR CLINICS ACKNOWLEDGMENT FORM

I acknowledge the following:

- It is important to my health that I show up on time for my doctor's appointment.
- If I do not show up for a scheduled appointment, it may affect my health and it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify my doctor's office at least 24 hours in advance when I need to cancel an appointment.
- My doctor may choose to terminate me from this practice if I have more than two no-show occurrences at any given time.

_____ _____

Signature Date

CLINIC REVIEW OF SYSTEMS

Patient's Name: _____

Date of Birth: _____ / _____ / _____

REVIEW OF SYSTEMS

Today's Date: _____ / _____ / _____

Please mark any symptom(s) you are currently having, or have experienced in the last two (2) weeks. If you are not having any of these symptoms please mark, "No Problems".

No Problems	

Constitutional / General Health	
Appetite change	
Excessive sweating	
Fatigue	
Fever	
Chills	
Night sweats	
Unexpected weight change	
Weight gain _____ lbs.	
Weight loss _____ lbs.	
Eyes	
Blurred vision	
Corrective lenses	
-- Contacts	
-- Glasses	
Decreased vision	
Diplopia (double vision)	
Eye irritation	
Eye pain	
Spots in vision	
Vision loss	
Ears, Nose, Mouth & Throat	
Ear pain	
Hearing loss	
Tinnitus (ringing in ears)	
Vertigo	
Facial pain	
Nasal discharge	
Nasal congestion	
Epistaxis (nose bleed)	
Postnasal drainage	
Bleeding gums	
Dental pain	
Mouth lesions	
Hoarseness	
Sore throat	
Cardiovascular (Heart)	
Chest pain	
-- At rest	
-- Upon exertion	
Decreased exercise tolerance	
Dizziness	
Dyspnea (difficult or labored breathing)	
-- At rest	
-- Upon exertion	
Orthopnea (shortness of breath when lying flat)	
Palpitations	
Pre-syncope (feeling as if you will faint)	

Cardiovascular (Heart) Cont.	
Syncope (fainting)	
Claudication (cramping pain in the leg induced by exercise)	
Leg ulcers	
Edema (swelling)	
Peripheral edema (swelling in the lower limbs)	
Respiratory	
Cough	
- Nocturnal (at night) cough	
- Productive cough	
- Nonproductive cough	
Hemoptysis (coughing up blood or blood-stained mucus)	
Shortness of breath	
Pleuritic (sudden, intense, sharp, stabbing, or burning pain in chest when inhaling or exhaling) pain	
Wheezing	
Snoring	
Apneas	
Gastrointestinal	
Abdominal pain	
Acid brash (regurgitation of saliva with some acid material from the stomach)	
Bloating	
Food intolerance	
Early satiety (feeling full after only a small amount of food)	
Fullness	
Epigastric discomfort (right below your ribs in the area of your upper abdomen)	
Nausea	
Vomiting	
Hematemesis (vomiting blood)	
Dysphagia (difficult swallowing)	
Reflux	
Heartburn	
Altered bowel habits	
Constipation	
Diarrhea	
Hematochezia (fresh blood in or with stools)	
Black stools	
Bloody stools	

Genitourinary (Kidney & Bladder)	
Change in urinary stream	
Dysuria (painful or difficult urination)	
Hematuria (blood in urine)	
Incontinence (lack of voluntary control over urination)	
Nocturia (getting up from sleep to urinate)	
Urinary frequency	
Urinary urgency	
Sexual dysfunction	
Female Patients Only	
Dysmenorrhea (painful period)	
Dyspareunia (painful intercourse)	
Vaginal discharge	
Menopausal	
Postmenopausal	
Last cycle: _____ / _____ / _____	
Male Patients Only	
Urinary dribbling	
Urinary hesitancy	
Penile discharge	
Musculoskeletal / Orthopedic	
Back pain	
Joint pain	
Joint swelling	
Limited range of motion	
Muscle aches	
Muscle weakness	
Stiffness	
Integumentary (Skin & Hair)	
Hair changes	
Lesions	
Changes in moles	
Pigment changes	
Pruritis (severe itching of skin)	
Rash	
Breast masses	
Breast skin changes	
Nipple discharge	
Neurologic (Brain & Nerves)	
Abnormal gait	
Dizziness	
Focal weakness	
Headache	
Incoordination	
Memory problems	
Numbness	
Numbness in feet	
Continued on next column	

Neurologic (Brain & Nerves)	
Numbness in hands	
Paresthesia (tingling, pricking, pins & needles) in feet	
Paresthesia (tingling, pricking, pins & needles) in hands	
Seizures	
Slurred speech	
Tremor	
Psychiatric (Mood & Thinking)	
Anxiety	
Decreased concentration	
Depression	
Dizziness	
Irritability	
Panic attacks	
Sleep disturbances	
Sadness/tearfulness	
Endocrinological (Glands)	
High blood sugar	
Low blood sugar	
High cholesterol	
Polydipsia (abnormally great thirst)	
Polyphagia (excessive hunger or increased appetite)	
Polyuria (frequent urination)	
Cold intolerance	
Heat intolerance	
Hematologic (Blood / Lymph)	
Bruising	
Bleeding tendencies	
Lymphadenopathy (enlarged lymph nodes)	
Recurrent infections	
Allergic / Immunologic	
Eczema	
Seasonal allergies	
Urticaria (hives)	
Any Symptoms not listed:	