MEDICAL WEST
an affiliate of the UAB HEALTH SYSTEM

Today's Date: ____________

Patient Information

Full Name: ______________________________ Date of Birth: ____________
Last First M.I.

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 Contacts

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: ____________

MW0004 2018/11

Patient Name: ______________________ DOB: ______________ Date: ______________

Primary Care Doctor: ______________________ Pharmacy: ______________ Pharmacy #: ______________

HEALTH HISTORY QUESTIONNAIRE

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

Visit Reason	☐ Annual ☐ Problem(s): 1.) ____________ 2.)

GYNECOLOGIC UPDATE

Date of last period?	How many days between periods?	Do you pass clots? ☐ Yes ☐ No
How many days does period last?	Flow: Light Medium Heavy	Bleeding between periods? ☐ Yes ☐ No
Are you menopausal/postmenopausal? ☐ Yes ☐ No	Have you had a hysterectomy? ☐ Yes ☐ No	
Do you use contraceptives? ☐ Yes ☐ No If yes, please list:		

CARE TEAM

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

MEDICAL PROBLEMS

☐ Asthma ☐ High Blood Pressure ☐ Cancer ____________ ☐ Kidney Problem(s) ☐ Diabetes

☐ Blood Clot(s) ☐ Heart Disease/Heart Failure ☐ Sleep Apnea ☐ Thyroid Problem(s)

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

SOCIAL HISTORY

Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
	Do you live alone? ☐ Yes ☐ No If no? ☐ With Family ☐ With Spouse ☐ Other
Employment	☐ Full Time ☐ Part Time ☐ 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	Do you routinely exercise?		☐ Yes ☐ No
	What kind?	How much?	How often?
Tobacco Use	☐ Current Tobacco User	☐ Former Tobacco User	☐ No
	What kind of tobacco?	How much?	How Often?
	Start date / age / year:	Quit date / age / year:	

Patient Name: ______________________ DOB: ______________ Date: ______________

FAMILY MEDICAL HISTORY

	If yes, please list relationship
Adopted: ☐ Yes ☐ No	
Cancer (List Type)	
Heart Disease/Stroke	
Stroke	
Diabetes	
Autoimmune Disease (List Type)	
Asthma	
Osteoporosis	

LIST ANY SIGNIFICANT FAMILY MEDICAL PROBLEMS THAT ARE NOT LISTED ABOVE

SURGICAL HISTORY

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

IMMUNIZATION HISTORY – IF A "BLUE CARD" OR CHILDHOOD IMMUNIZATION HISTORY IS AVAILABLE PLESE PROVIDE A COPY

☐ HPV (2, 4, or 9)	☐ Completed	☐ Pneumococcal Polysaccharide (PPSV23)	Date
☐ Influenza (Flu Vaccine)	☐ Completed	☐ Tetanus, Diphtheria, Pertussis (Tdap)	Date
☐ Pneumococcal Conjugate (PCV13)	Date	☐ Other:	

PREVIOUSLY PERFORMED TESTS AND SCREENINGS

☐ Colonoscopy	Date	☐ Pap Smear ☐ with HPV	Date
☐ Cologuard	Date	☐ GYN/Well Woman Check Up	Date
☐ DEXA – Bone Density	Date	☐ Other:	Date
☐ Fecal Occult Blood (stool card)	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	Medication Name	Strength	Frequency

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

1.	5.
2.	6.
3.	7.
4.	8.

Patient Name: ______________________ DOB: ______________ Date: ______________

REVIEW OF SYSTEMS

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 ☐

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Constitutional		**Genitourinary**		**Psychiatric**	
Fatigue		Dysuria/Painful Urination		Anxiety	
Fever		Blood in Urine		Depression	
Weight Loss		Incontinence		Difficulty Sleeping	
Weight Gain		Frequency of Urination		Frequent Crying	
Night sweats		Urgency to Urinate		**Endocrine**	
Hot Flashes		Postmenopausal		Cold Intolerance	
Eyes, Ears, Nose, & Throat		Vaginal Discharge		Heat Intolerance	
Blurred/Impaired Vision		Pelvic Pain		**Hematologic**	
Decreased Vision		**Musculoskeletal**		Easy Bruising	
Vertigo/Lightheadedness		Joint Pain		Bleed Easily	
Facial Pain		Muscle Pain/Aches		Enlarged Lymph Glands	
Mouth Lesions		Muscle Weakness		Blood Transfusions	
Sore Throat		**Skin**		**Allergic/Immunologic**	
Cardiovascular		Hair Loss		Eczema	
Chest Pain		Moles (new growth or changes)		Seasonal Allergies	
Palpitations		Rash		**Any Symptoms Not Listed**	
Respiratory		**Breast**			
Cough		Lumps			
Hemoptysis (Coughing up Blood)		Tenderness			
Shortness of Breath		Swelling			
Wheezing		Nipple Discharge			
Gastrointestinal		**Neurologic**			
Nausea/vomiting		Headaches			
Constipation		Memory Difficulties			
Diarrhea		Numbness			
Blood in Stool		Seizures			

FORM COMPLETED BY: ☐ Patient ☐ Office Nurse ☐ Physician ☐ Other: ______________

Note Regarding Annual Exams

A yearly exam without a co-pay does not apply to visits addressing problems or complaints (such as abnormal bleeding, menopausal symptoms, breast pain, etc.). For our patients' convenience, our physicians are very pleased to address any concern or problem you may have at the same time as your yearly exam. Please be aware, however, that an office visit will be submitted to your insurance company and a co-pay may be required.

______________________ ______________

Patient Signature Date

______________________ ______________

Physician Signature Date

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Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information (MW119)

Patient Name ______________________ Date of Birth ______________________

Social Security Number ______________________ Primary 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 MDICAL 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 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 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.

______________________ Signature of Patient/Legal Guardian/Responsible Party ______________________ Date

______________________ Printed Name of Legal Guardian/Responsible Party ______________________ Relationship to Patient

Clinic HIPPA
MW0258 (10/20/19)

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No Show/Cancellation Acknowledgement

Applicable at all Medical West Health Centers

Printed Name of Patient ______________________ Date of Birth ____________

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 of Patient/Legal Guardian/Responsible Party ______________________ Date ____________

Printed Name of Legal Guardian/Responsible Party ______________________ Relationship to Patient ____________

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Travel Screening

Date: ____________________

Name: ______________________________ Date of Birth: ____________________

Have you traveled outside the United States in the last 21 days? Yes or No

If No- stop

If yes, where?

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Have you had a fever of 101.5 or above since returning? Yes or No

If yes, what date did the fever start? ______________

Are you experiencing any of the following?

☐ Muscle Pain	☐ Diarrhea	☐ Severe Headache	☐ Lack of appetite
☐ Weakness	☐ Vomiting	☐ Abdominal Pain	☐ Unusual Bleeding