Patient Name_____ Maiden/Other Name_____

Birth Date_____ Sex M/F SSN_____ Race_____

Address_____ City/St/Zip_____

Home Phone_____ Cell_____ Marital Status_____

Religion_____ Email Y/N Email_____

Student Y/N School Name_____ Grade_____

Employer_____ Occupation_____

Employer's Address_____ City/St/Zip_____

Employer's Phone_____

Next of Kin_____ Relationship to Patient_____

Address_____ City/St/Zip_____

Home Phone_____ Cell_____

Alternate Contact_____ Relationship to Patient_____

Address_____ City/St/Zip_____

Home Phone_____ Cell_____

Guarantor_____ (If same as patient, please sign and skip this section)

Guarantor's Address_____ City/St/Zip_____

Guarantor's Phone_____ Cell_____ Email_____

Relationship to Patient_____ Guarantor's SSN_____

Guarantor's Employer_____ Occupation_____

Guarantor's Employer Address_____ City/St/Zip_____

MEDICAL WEST
OB/GYN HEALTH CENTER
an affiliate of the UAB HEALTH SYSTEM
985 9th Avenue SW, Suite 500, Bessemer, AL 35022 • 205-481-7750

MEDICAL WEST
an affiliate of the UHS HEALTH SYSTEM

Personal Health History I

Welcome to Medical West Health System! We look forward to getting to know you better. Please help us to provide you with the best medical care possible by answering the following questions as completely and accurately as you can.

Name:			**Date of Birth:**		
Reason for first visit to the Clinic:					
Date form completed:					
HISTORY OF PREVIOUSLY DIAGNOSED MEDICAL CONDITIONS					
Have you ever had?	**Yes**	**No**	**Have you ever had?**	**Yes**	**No**
Abnormal Pap Smear (women)			Heart attack or angina		
Acid reflux or Heartburn			Heart murmur / valve disorder		
Asthma			Hepatitis or cirrhosis		
Atrial Fibrillation			High Blood Pressure		
Anemia			Inner ear trouble / vertigo		
Alcohol or other drug abuse			Kidney Stones		
Arthritis			Memory loss or dementia		
Back pain (chronic) or sciatica			Migraine (or other) headaches		
Bleeding or bruising problems			Neuropathy		
Blood clots or phlebitis			Osteoporosis		
Cancer (List type below)			Panic attacks		
Circulation problems			Pneumonia		
Colon polyps			Prostate trouble (men)		
Depression or nerve problems			Rheumatic Fever		
Diabetes			Stomach ulcers		
Diverticulitis or diverticulosis			Stroke or TIA		
Emphysema or COPD			Thyroid disease or goiter		
Epilepsy or Seizures			Tuberculosis		
Gallstones			Urinary tract infections		
Glaucoma			Venereal disease		
Please provide more information below regarding any "Yes" answers, or list other medical problems that your physician should know about.					

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Personal Health History II

PAST SURGICAL HISTORY (Operations)

Surgical Procedure	Date	Surgical Procedure	Date

OB GYN HISTORY (For Women)

Are you pregnant now? ☐Yes ☐No	Are you trying to get pregnant? ☐Yes ☐No
Number of prior pregnancies?	
Number of live births?	
Number of miscarriages / terminated pregnancies?	

Names of Other Treating Physicians	Immunization History	Yes	No	Last Date
	Tetanus Vaccine			
	Pneumonia Vaccine			
	Influenza Vaccine			
	Hepatitis Vaccine			
Have you previously had any of these tests performed?	Mammogram			
	Bone Density Study			
	Colonoscopy			
	PSA			
	TB Skin Test?	Positive	Negative	

ALLERGIES: List drug, food or other item and type of allergic reaction experienced below
Or check box to indicate No Known Allergy ☐NONE

Name of Drug/Item	Reaction	Name of Drug/Item	Reaction

PERSONAL HABITS/RISK FACTORS

	Yes	No	
Do you smoke or chew tobacco?			No. packs/day:
Have you ever smoked in the past?			Date stopped?
Do you drink alcohol?			How many drinks per day?
Have you ever had an alcohol problem?			Describe?
Have you ever used any "street" drugs?			Describe?
Do you exercise regularly?			How much?
Do you have an eating problem?			Describe?

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Personal Health History III

MEDICATION HISTORY

List the names, strength, dosage and frequency of all prescription medications, vitamins, over-the-counter medications, health food supplements

Medication	Strength (Mg, etc)	How often do you take this?

SOCIAL HISTORY

Are you married? ☐Yes ☐No Are you divorced? ☐Yes ☐No

Do you work outside the home? ☐Yes ☐No Are you retired or disabled? ☐Yes ☐No

What kind(s) of jobs have you done?

Do you have a Living Will or Advance Directive? ☐Yes ☐No

FAMILY MEDICAL HISTORY

Please indicate if there is history of any of the medical conditions listed below in members of your immediate family and provide more information if possible.

Medical Condition			Details about family history
Diabetes	Yes	No	
Heart Disease	Yes	No	
Cancer	Yes	No	
Other Conditions	Yes	No	

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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 _____ 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 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 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.

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

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

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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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an affiliate of the UPMC HEALTH SYSTEM

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