MEDICAL HISTORY QUESTIONNAIRE

alpha
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Legal Last Name: ______________________ **Legal First Name:** ______________________

Preferred Name: ______________ **Date of Birth:** ____/____/_____ **Social Security Number:** ______________

Address: ____

City: ______________________ **State:** __________ **Zip:** ______________ **County:** ______________

Home Phone: ______________________ **Cell Phone:** ______________________

Email: ____

Preferred Contact (check one): □ Home □ Cell □ Email □ Patient Portal

Sex at Birth: □ Male □ Female □ Other______________ **Gender Identity:** □ Male □ Female □ Other______________

Sexual Orientation: □ Straight/Heterosexual □ Lesbian/Gay/Homosexual □ Bisexual □ Other______________

Primary Care Physician: ______________________ **Referring/Specialty Dr:** ______________________

Pharmacy: ______________________ **Location (Street & City):** ______________________

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Unspecified

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese □ Russian □ Spanish □ Other______________

Insurance Information (Please Present Card):

Policy Holder's Name: ______________________ **Relation to Patient:** ______________________

Insurance Company: ______________ **Group Number:** ______________ **Member ID:** ______________

Allergies

______________________ Reaction: ______________________ □ Mild □ Moderate □ Severe

______________________ Reaction: ______________________ □ Mild □ Moderate □ Severe

______________________ Reaction: ______________________ □ Mild □ Moderate □ Severe

Current Medications, including birth control (ex. IUD's) (Please list all, including dosage and frequency)

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Social History (Please mark all that apply)

Smoking: □ Current Every Day Smoker □ Current Some Days Smoker □ Former Smoker □ Never Smoked

Alcohol Use: □ Yes □ No □ Former **What and how often?** ______________________

Drug Use: □ Yes □ No □ Former **What and how often?** ______________________

Injection Drug Use: □ Yes □ No □ Former **What and how often?** ______________________

Annual Income: □ Below $12,490 □ $12,491-$24,980 □ $24,981-$37,470 □ $37,471-$49,960 □ $49,961-$62,450 □ $62,451 or Above

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Organ Inventory

Does your body **CURRENTLY** include	**Yes**	**No**
Penis		
Testes		
Prostate		
Breasts (Female)		
Vagina		
Cervix		
Uterus		
Ovaries		

Historic or Current Infections (Please mark all that apply)

□ Overall Healthy □ Herpes Simplex □ HIV / AIDS	□ Syphilis □ Chicken Pox □ Herpes Zoster / Shingles	□ Meningitis □ Toxoplasmosis □ Hepatitis A / B / C	□ Histoplasmosis □ MRSA □ Wound Infection

Patient Signature: ____ **Date:** __________________________

Guardian Signature (If under 14): ____ **Date:** __________________________

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient: ____

Signature of Guardian (If under 14): ____

Patient Name: ____ Date: __________________________

By signing this consent form you are giving your healthcare provider permission to collect your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Consent to Treatment

I hereby give my permission for **Allies Linked for the Prevention of HIV and AIDS, dba: a.l.p.h.a.** (the Practice) to give me medical treatment.

I allow the Practice to file for insurance benefits, if I have provided a carrier, to pay for the care I receive.
I understand that:

- The Practice will have to send my medical record information to my insurance company if I provide one.
- My tester will inform me of any testing or treatment that could result in a cost I will be asked to pay.
- I may be financial liable for the cost of these services.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Signature of Patient: ____

Signature of Guardian (If under 14): ____

Patient Name: ____ Date: __________________________

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I have read and understand this document: ____

[signature]

Date:________________________