Esteban N. Berberian, M.D.

Mailing Address:
P.O. Box 1939
Channelview, TX 77530

Internal Medicine
Phone: (281) 247-8020
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Facility Address:
15201 East Freeway #103
Channelview, TX 77530

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care.

Our Duties

We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect. We will not use or disclose your health information without your authorization, except in the following situations:

Treatment: We will use and disclose your health information while providing, coordinating or managing your health care. For example, information obtained by a technician, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We may also provide other healthcare providers with your information to assist him or her in treating you. An example of this might be if we refer you to a specialist for further care or order a test that requires health information, such as an MRI.

Payment: We will use and disclose your medical information to obtain or provide compensation or reimbursement for providing your health care. For example, we may send a bill to you or to your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As another example, we may disclose information about you to your health plan so that the health plan may determine your eligibility for payment for certain benefits.

Health Care Operations: We will use and disclose your health information to deal with certain administrative aspects of your health care, and to manage our business more efficiently. For example, members of our medical staff may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. We may disclose your health information to our business associate so they can perform the job we have asked them to do. However, we require the business associate to take precautions to protect your health information.

Communication With Family: We may disclose to a family member, other relative, close friend or any other person you identify, health information relevant to that person's involvement in your care. We will ask you to put in writing which family members, etc. you want to have access to information about your treatment and care.

Research: Consistent with applicable law we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Director, Coroner, And Medical Examiner: Consistent with applicable law we may disclose health information to funeral directors, coroners, and medical examiners to help them carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food And Drug Administration: We may disclose to the FDA health information relative to adverse events, product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse and neglect.

Victims Of Abuse, Neglect Or Domestic Violence: We may disclose your health information to appropriate governmental agencies, such as adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Health Oversight: In order to oversee the health care system, government benefits programs, entities subject to governmental regulation and civil rights laws for which health information is necessary to determine compliance, we may disclose your health information for oversight activities authorized by law, such as audits and civil, administrative, or criminal investigations.

Court Proceeding: We may disclose your health information in response to requests made during judicial and administrative proceedings, such as court orders or subpoenas.

Law Enforcement: Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Threats To Public Health Or Safety: We may disclose or use health information when it is our good faith belief, consistent with ethical and legal standards, that it is necessary to prevent or lessen a serious and imminent threat or is necessary to identify or apprehend an individual.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Other Uses:

(1) Appointment Reminders: It is our practice to make a reasonable effort to reach you to remind you of your upcoming appointment. This will be done by leaving a generic message at home or work or on your answering machine, if we cannot reach you in person. (2) Recall Notices: It is our practice to send out recall notices to notify you that it is time for an exam. We do this by sending out postcards with a generic message on it. (3) Notification of results: If your lab results, radiology reports, or any other reports come back, the staff will try to contact you by person or failing that will leave a message on your home answering machine that your results are in. If you have signed an authorization to leave results on your answering machine, the staff will do so. (3) To describe or recommend treatment alternatives to you.
(4)To furnish information about health-related benefits and services that may be of interest to you.

Prohibition On Other Uses Or Disclosures

We may not make any other use or disclosure of your personal health information without your written authorization. Once given, you may revoke the authorization by writing to the contact person written below.
Understandably, we are unable to take back any disclosure we have already made with your permission.

Individual Rights

You have many rights concerning the confidentiality of your health information. You have the right:

□ To request restriction on the health information we may use and disclose for treatment, payment, and healthcare operations. We are not required to agree to these requests. To request restrictions, please send a written request to the address below.

□ To receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. To make such a request, you must write to us at the address below, and tell us how or where you wish to be contacted.

□ To inspect or obtain a copy your health information. You must submit your request in writing to the address below. If you request a copy of your health information, we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances, we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

□ To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if:

□ The information was not created by us, unless the person that created the information is no longer available

to make the amendment, the information is not part of the health information kept by or for us, is not part of the information you would be permitted to inspect or copy, or is accurate and complete

□ To receive an accounting of certain disclosures of your health information. You must submit a request in writing to the address below. Not all health information is subject to this request. Your request must state a time period, no longer that 6 years and may not include dates before Mach 24, 2003. Your request must state how you would like to receive the report (paper, electronically). The first accounting you request within a 12-month period is free. For additional accounting, we may charge you the cost of providing the accounting. We will notify you of this cost and you may choose to withdraw or modify your request before charges are incurred.

□ To receive a paper copy of this Notice upon request, you may pick up a copy of this or send a request for a paper notice in writing to the address below. All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed below.

Complaints

If you believe that your privacy rights have been violated, a complaint may be made to our privacy officer at the address listed below. For documentation purposes, all complaints must be made in writing. You may also submit a complaint to the Secretary of the Department of Health and Human Services.

Contact Person

For all questions, requests or for further information related to the privacy of your health please contact the privacy officer at:

Esteban N. Berberian, MD PA
P.O. Box 1939
Channelview, TX 77530
ATTENTION: PRIVACY OFFICER

Changes To This Notice

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.
Notice Effective Date: March 24, 2009

Esteban N. Berberian, MD PA

Patient Financial Responsibilities Policy

Esteban N. Berberian, MD PA welcomes you to its family healthcare providers. We are pleased you have chosen us to care for you and we commit to enhance the value and quality of your care. This policy statement is intended to answer questions you may have regarding payment for services rendered at our facilities or in the hospital setting by members of the group. Your questions and comments are welcomed.

While we hope to maintain a longstanding relationship with you, we must ensure all patients follow our policies. We require all our patients to read and sign this document and we will maintain this in our files. Failure to adhere to these financial policies can result in dismissal from the practice.

Payment for Services

For your convenience, we accept cash, VISA, MasterCard, debit cards, money orders and personal checks after the first visit. Starter checks and post-dated checks are not accepted. A valid picture ID is required on all checks. If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered.

Cancellation/No Show Policy

To ensure that all our patients have access to our physicians, we have established the following fees for late cancellations and no shows. Office visits cancelled less than 24 hours of the appointment will be subject to a charge of $25.00. This charge will be inputted on the day of missed visit and will need to be paid in full before you next visit. These charges will be billed to the patient and not their insurance carrier. This is not something we wanted to do but feel we need to do, due to the increasing number of cancellations. Please be courteous and call at least 24 hours in advance if you need to cancel so that someone else will be able to use your appointment time. Our hopes are that with this policy all patients will do this so that each patient has the opportunity to have appointments sooner. We do have a reminder call system that will call you the day before your appointment. Please make sure you have the most current phone number on file with us at all times.

Self-Pay Patients

The group welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay in full at the time of service. If you are any established patient and for any reason you may be unable to pay in full at the time of service, speak with the billing manager in advance of the visit to determine if reasonable payment arrangements can be established with the practice. New patients without insurance are required to pay a $125.00 retainer when checking in. This will be applied to your visit and you will be asked for the balance or if the visit is less than $125.00, you will be refunded the difference during checkout.

Returned Checks

There is a $25.00 fee for all returned check as a fee is charged to us from the bank for all returned checks. The returned check fee will need to be paid prior to your next appointment. If a check is returned, you will need to pay all future visits via cash, debit card, or credit card.

Medical Records

You must request all medical records request in writing even if it is for yourself. Medical records are sent as a courtesy to another physician's office free of charge. If you are requesting a paper or electronic copy of your records to take with you, there is a varying fee depending on the size of the chart and actual cost of compiling records. If you are needing a part of your record for another physician or to transfer physician's it is best to fill out a form at either our office or theirs and have the records sent directly to them so no fees are incurred.

Filling out Forms

For your convenience, our physicians will fill out forms for our patients. These forms include FMLA, short-term disability, and long-term disability forms. The fee for this service is $15.00. This fee must be paid when the form is mailed or dropped off at the practice. If you are mailing in the form, a check should be mailed with the form. Patients are not required to pay a fee for State disability forms.

Insurance Coverage

Your Physician's Participation with Your Insurance Plan

Our group accepts most major insurance plans. Prior to your initial visit, please contact your insurance carrier to confirm that the physician you will be seeing participates in your plan. It is the patient's responsibility to make sure that all visits with all procedures order, lab orders, and specialists referred to, are in-network with your insurance's plan. Our office is not responsible for any balances due for out of network benefits.

Our staff will assist you with any information your insurance carrier may need to clarify our physician's participation with your plan.

If our practice does not participate with your insurance plan, you will be responsible for payment of all charges at the time of your visit. You will be provided an itemized bill which you may submit to your insurance plan for any reimbursement for which you may be eligible.

Current Insurance and Patient Demographic Information

If your physician participates with your insurance plan, we will file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurances or services that are not covered by your plan. For the practice to file your insurance, we must have a valid picture ID, the current insurance coverage(s) and be made aware of any changes in either insurance or patient address or phone numbers. Please bring your insurance card to every visit so that we can confirm your coverage. Otherwise, the visit will be considered self-pay and you will be required to pay the balance in full. We will not be able to bill your insurance for a self-pay visit.

Patient Payment Responsibility for Non-Covered Services

We treat based on patient need and not based on insurance. In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. We may request payment for any known, non-covered services at the time of your visit; otherwise they will be billed to you at a later date. Due to numerous health care plans, we cannot verify every procedure done in our office. If a procedure done in our office is not covered, you will be responsible for the billed amount. Please call your insurance to make sure your procedure is covered.

Managed Care Insurance (HMO, POS & PPO plans)

Patients with managed care health plans will be expected to follow the payment-at-time-of-service requirements of the particular plan under which they are covered. Managed care patients will not receive monthly statements except for balance owed.

Your managed care plan may require a referral from your PCP in order to pay for your visit to a specialist. Please make sure you have obtained any required referrals in advance of your visit. If your insurance plan requires a referral and you do not have one, please notify us at least 48-72 hrs in advance of your visit. If you or the specialist's office contacts us without notice you will be asked to reschedule your appointment to give us time to obtain a referral/authorization.

Your managed care plan may also require prior authorization (precertification) prior to any outpatient procedures performed by our physicians. Our staff or a third party vendor will assist in obtaining prior authorization for outpatient services that are considered medically necessary. Some screenings such as Colonoscopy screening and mammograms may not be covered by your insurance plan even if it is recommended by your physician. You are responsible for calling your insurance carrier to ensure that routine screenings are a covered benefit under your insurance plan.

Indemnity/Discount Insurance

Our group does not contract with indemnity insurance plans or discount plans. If payment is not received within 60 days from the time the claim is filed, the visit will be changed to self-pay status. Patient will be responsible for the self-pay balance.

Medicare Insurance

Our physicians accept Medicare assignment on covered Medicare charges. Payment for the 20% Medicare coinsurance, annual deductible, or any non-covered charges is expected at the time of service unless you have secondary insurance accepted by the group (see "Secondary Insurance" policy below).

Medicare may not pay for certain services it determines to be medically unnecessary. If there is a possibility that a service provided in our office may fall into this category, you will be asked to sign an advanced beneficiary notice indicating that you acknowledge this possibility and that you agree to pay for all services Medicare determines to be medically unnecessary.

Medicaid Insurances

Patients must show proof of current Medicaid eligibility (current Medicaid card or form) prior to seeing a physician. We currently do not accept new Medicaid only patients and accept Medicaid as a secondary only to Medicare if the patient is already an established patient when first receiving Medicaid.

Worker's Compensation Insurance

We do not accept worker's compensation insurance. Established patients with a worker's compensation case will be required to go to a physician/facility that accepts worker's compensation insurance. We will not be able to see you for any worker's compensation injuries.

Secondary Insurance

We file secondary insurance only for plans accepted by the group. We allow 60 days from the date of service for your secondary payer to pay. Beyond 60 days, unpaid secondary balances are patient responsible.

Collections

Statements are sent out monthly to all patients to the address provided to us. Please make sure you provide us with any changes to your address. If payment is not made for balance owed within 90 days or the patient has not called to make payment arrangements, the account will automatically be sent to collections. Please make sure you contact our billing department to discuss any billing questions. Once in collections, you will be required to pay your balance in full before your next appointment is scheduled. Collections agencies report balances to credit bureau. We like to give each patient every opportunity to avoid being sent to collections, so please call us to discuss your balance and make payment arrangements. We do not want any of our patients sent to collections.

Changes To This Policy

We reserve the right to change our Patient Financial Responsibilities Policy as needed. Any revision to our Patient Financial Responsibilities Policy will be described in a revised Notice that will be posted prominently in our facility.

Notice Effective Date: January 1st, 2018

Esteban N. Berberian, M.D.

15201 East Freeway Suite 103
Channelview, Texas 77530

PATIENT INFORMATION

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date _____/_____/_____

Name: _____
Last *First* *M.I.*

Date of Birth: _____/_____/_____ Age: _____Social Security #_____ - _____ - _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____Date of Birth: _____/_____/_____
Last *First* *M.I.*

Address: _____
City *State* *Zip*

Home Phone: ( ) _____ - _____Work Phone: ( ) _____ - _____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name: _____Phone: ( )_____ - _____ Ext:_____

Address of Claim Center: _____
City *State* *Zip*

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: _____/_____/_____ SS#_____ - _____ - _____ Sex: ☐Male ☐Female

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO ☐ POS ☐ OTHER

Employer Name: _____

Employer Address: _____
City *State* *Zip*

If patient is child, check relationship: ☐ Mother ☐ Father ☐Other_____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name: _____Phone: ( )_____ - _____ Ext:_____

Address of Claim Center: _____
City *State* *Zip*

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: _____/_____/_____ SS#_____ - _____ - _____ Sex: ☐Male ☐Female

Patient: _____ **Age:** _____ **Date:** _____

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO ☐ POS ☐ OTHER

Employer Name: _____

Employer Address: _____

City *State* *Zip*

If patient is child, check relationship: ☐ Mother ☐ Father
☐ Other_____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified?

Name: _____ Relationship: _____

Phone # (day): ( ) _____ - _____ Phone # (evening): ( ) _____ - _____

Are you Allergic to any medicine? ☐ YES ☐ NO if yes, please list:

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

Do you give our office permission to discuss your medical information with family members?

☐ YES ☐ NO If yes, please provide their names and phone numbers below:

Name: _____ Relationship: _____

Phone # (day): ( ) _____ - _____ Phone # (evening): ( ) _____ - _____

Name: _____ Relationship: _____

Phone # (day): ( ) _____ - _____ Phone # (evening): ( ) _____ - _____

Name: _____ Relationship: _____

Phone # (day): ( ) _____ - _____ Phone # (evening): ( ) _____ - _____

May we leave personal medical information such as lab results, radiology reports results, medication changes, refill information or other general call back information on your answering machine or voice mail on all phone numbers you have provided on this form?

☐ YES ☐ NO (If you state yes, this authorization will remain in effect until you notify us in writing to change it.)

May we e-mail personal medical information such as lab results, radiology reports results, medication changes, refill information or other general call back information to you?

☐ YES ☐ NO E-mail address: _____

Patient or Responsible Party Signature _____ Date _____/_____/____

Patient: _____ **Age:** _____ **Date:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date _____/_____/_____

RECEIPT OF PATIENT FINANCIAL RESPONSIBILTIES POLICY:

My signature below indicates that I have received and/or reviewed a copy of my physician's Patient Financial Responsibilities Policy.

Patient or Responsible Party Signature _____ Date _____/_____/_____

ASSIGNMENT & RELEASE

I, the undersigned, have insurance with_____ and assign directly to Dr. Esteban N. Berberian, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____/_____/_____

Signature of Insured / Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Esteban N. Berberian for any services furnished to me by the Doctor. I authorize the holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or else on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance, and non-covered service. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

_____ _____/_____/_____

Beneficiary Signature Date

GENERAL CONSENT FOR TREATMENT

Having come to Esteban N. Berberian, MD PA for evaluation or treatment, I (or authorized representative on my behalf) hereby consent to and authorize Esteban N. Berberian, MD PA and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____/_____/_____

Patient/Other Legally Responsible Person Date

Esteban N. Berberian, M.D.

15201 East Freeway, Suite #103
Channelview, Texas 77530

INITIAL/COMPREHENSIVE VISIT: 20__

Patient: _____ **Age:** _____ **Date:** _____

Birth Date: _____ **Referred by:** _____ **Last Doctor:** _____

CC: _____

H.P.I.

Drug Reaction:

☐ Penicillin/Sulfa ☐ Aspirin
☐ Codeine
☐ Other _____

Environmental Allergies:

☐ Food ☐ Insects
☐ Plants ☐ Animals
☐ Latex
☐ Other _____

Medications:

(Include over-the-counter)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____

Vaccinations:

Type:	Date:
☐ Influenza (Flu)	_____
☐ Pneumonia	_____
☐ Hepatitis	_____
☐ Tetanus	_____

☐ Other _____

Hospitalizations:

Month/Year:	Reason:
_____	_____
_____	_____
_____	_____

Surgeries:

☐ Appendectomy ☐ Gall bladder
☐ Hysterectomy ☐ Cataract
☐ Heart ☐ Lap band
☐ Other _____
_____

Injuries:

☐ Broken bones ☐ Sprains
☐ Dislocations ☐ Cut/lacerations
☐ Other _____

Transfusions:

☐ Yes ☐ No

Family History:

Check if relative had any of these:

☐ High Blood Pressure ☐ Heart Disease
☐ High Cholesterol ☐ Emphysema
☐ Heart Failure ☐ Migraines
☐ Diabetes ☐ Stroke
☐ Cancer ☐ Asthma
☐ Other _____

Habits:

☐ Drink coffee/soda
☐ Smoker____ packs/day for____ years
Currently smoking ___ packs/day
Stopped smoking ___ ago
☐ Chew(ed) tobacco
☐ Drink alcohol ___ glasses/day
☐ Drug use
☐ Intravenous drugs use

Social History:

Marital status:

☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated

Highest level of education:

☐ High school/GED ☐ Some college
☐ A.A./A.S./Technical ☐ Bachelors

Occupation: _____

Needs daily assistance with:

☐ Bathing ☐ Dressing
☐ Toileting ☐ Feeding
☐ Medication ☐ Transportation
☐ Other _____

Sexually active: ☐ Yes ☐ No

Exercise regularly ☐ Yes ☐ No

Obstetric History:

_____ Age of first menstrual cycle
_____ Number of pregnancies
_____ Number of normal vaginal births
_____ Number of cesarean sections
_____ Age of menopausal onset

Personal Medical History:

Have you ever had:
(Check all that apply)

☐ High blood pressure ☐ Glaucoma
☐ Heart disease ☐ Skin problems
☐ Diabetes ☐ Cancer
☐ High cholesterol ☐ HIV
☐ Asthma ☐ Tuberculosis
☐ Bronchitis ☐ Bladder problem
☐ Emphysema ☐ Rheumatic fever
☐ Peptic ulcer/reflux ☐ Pneumonia
☐ Colitis/bowel disease ☐ Chicken pox
☐ Hepatitis ☐ Measles
☐ Infertility ☐ German measles
☐ Thyroid problems ☐ Gonorrhea
☐ Anemia ☐ Syphilis
☐ Arthritis/gout ☐ Whooping cough
☐ Back problems ☐ Scarlet fever
☐ Migraines ☐ Polio/meningitis
☐ Seizures ☐ Kidney problems
☐ Stroke ☐ Gall bladder
☐ Depression ☐ Poisoning
☐ Mental illness
☐ Other _____

Previous Tests:

Test	Date	Test	Date
☐ EKG	_____	☐ PSA	____
☐ Chest XRay	_____	☐ Pap smear	____
☐ Stress test			____
☐ Mammogram			____
☐ Stool for occult blood			____
☐ Colonoscopy			____

☐ Other _____

Patient: _____ **Age:** _____ **Date:** _____

Review of Systems

Constitutional
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Night sweats

Head/Eyes
- ☐ Headaches
- ☐ Head injury
- ☐ Blurred vision
- ☐ Cataracts
- ☐ Glasses/contacts

Ear/Nose/Throat
- ☐ Ear ache/injury
- ☐ Hearing loss
- ☐ Constant ringing in ear/s
- ☐ Dizziness
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Dentures
- ☐ Cavities
- ☐ Gum swelling/irritation

Cardiorespitory
- ☐ Chest pain/pressure
- ☐ Palpitations
- ☐ Light headedness
- ☐ Shortness of breath when lying down
- ☐ Blackout/fainting
- ☐ Leg swelling
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing up blood

Gastrointestinal
- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Dark stool(feces)
- ☐ Red blood in stool
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Pale stool(feces)
- ☐ Swelling in abdomen

Genitourinary
- ☐ Painful urination
- ☐ Sudden urges to urinate
- ☐ Frequent urination
- ☐ Difficulty starting urination
- ☐ Frequent urinary tract infections
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate problems

Gynecological
- ☐ Pelvic pain
- ☐ Menstrual problems
- ☐ Vaginal discharge
- ☐ Missed periods
- ☐ Breast tenderness
- ☐ Breast discharge
- ☐ Lump in breast
- ☐ Menopause
- ☐ Hormone replacement

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Redness in joints
- ☐ Back pain/stiffness
- ☐ Jaw pain

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive volume with urination
- ☐ Swollen glands in neck

Neurologic
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Difficulty with memory
- ☐ Snoring
- ☐ Daytime drowsiness
- ☐ Morning headaches
- ☐ Seizures

Psychiatric
- ☐ Anxiety
- ☐ Nervous tension
- ☐ Feelings of depression
- ☐ Suicidal thoughts
- ☐ Crying spells
- ☐ Uncontrollable anger
- ☐ Currently receiving psychiatric treatment
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Integumentary
- ☐ Skin rash
- ☐ Blisters
- ☐ Athlete's foot
- ☐ Toenail fungus
- ☐ Fingernail fungus
- ☐ Hair loss
- ☐ Acne

Additional information/Patient Notes:

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_____

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Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? ❑ Yes ❑ No
2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No
3. Do you experience symptoms of allergies? ❑ Yes ❑ No