



New Patient Health Questionnaire

Date: ___/___/___

Patient: _____

Gender: M F

Date of Birth: ___/___/___ **Age:** ___

Occupation _____

Referring Doctor: _____

Reason for your visit: _____

Prior Heart Disease and Testing:

Heart murmur/Valve Prolapse....**NO YES**
Rheumatic/Scarlet Fever..... **NO YES**
Angina/Chest Pain..... **NO YES**
Heart Attack..... **NO YES**
Heart Cath/Angioplasty/Stent.... **NO YES**
Bypass Surgery.....**NO YES**
Pacemaker..... **NO YES**
Defibrillator..... **NO YES**

Heart Failure.....**NO YES**
Stress Test.....**NO YES**
Echo/Ultrasound.....**NO YES**
Calcium Scoring.....**NO YES**
Carotid Ultrasound.....**NO YES**
CT Angiogram.....**NO YES**
Holter Monitor..... **NO YES**
Nuclear PET scan.....**NO YES**

Risk Factors For Heart Disease:

Numbness/Tingling of legs..... **NO YES**
Female menopause..... **NO YES**
Stroke or TIA (ministroke)..... **NO YES**
Current Smoker..... **NO YES**
Previous Smoker..... **NO YES**

Diabetes.....**NO YES**
Leg Cramps walking..... **NO YES**
Venous (leg) clots..... **NO YES**
Pulmonary embolism.... **NO YES**

Quit: Year: _____

Medications:

Please list all prescription and non-prescription medicines including vitamins and aspirin.

	Name	Dose/Strength	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

DO YOU HAVE ANY ALLERGIES TO MEDICATION? NO YES

Please list all medications to which you have an allergy or adverse response and list the reaction.

	Medication	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Do you have an allergy to IODINE, SHRIMP, or SHELLFISH? **NO** **YES**
Have you received X-ray contrast (IVP, myleogram, CT scan) **NO** **YES**
If yes, did you have any reaction to the contrast? **NO** **YES**

FAMILY HISTORY

Please indicate with an **X** all those immediate family members with the following conditions.

	Father	Mother	Brother(s)	Sister(s)
1. Angina	_____	_____	_____	_____
2. Heart Attack	_____	_____	_____	_____
3. Angioplasty/Stent	_____	_____	_____	_____
4. Heart Bypass	_____	_____	_____	_____
5. Other Heart Surgery	_____	_____	_____	_____
6. Heart Failure	_____	_____	_____	_____
7. Stroke	_____	_____	_____	_____
8. Heart Valve Problem	_____	_____	_____	_____
9. Congenital Heart Disease	_____	_____	_____	_____
10. Hypertension	_____	_____	_____	_____
11. Abnormal Cholesterol	_____	_____	_____	_____
12. Diabetes	_____	_____	_____	_____
13. Abdominal Aortic Anuerysm	_____	_____	_____	_____
14. Pacemaker/AICD	_____	_____	_____	_____
15. Sudden Death	_____	_____	_____	_____

Father's age at death and cause, if deceased: _____

Mother's age at death and cause, if deceased: _____

Brother/Sister age at death and cause if deceased: _____

Please list all past surgeries/hospitalizations and dates: _____

Briefly describe any other past medical problems: _____

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PATIENT REGISTRATION FORM

Today's date		<input type="checkbox"/> Office		<input type="checkbox"/> Facility		<input type="checkbox"/> Home			
PATIENT INFORMATION									
Patient's Name Last			First			MI		Single / Mar / Div / Sep / Wid	
Date of Birth		Age		<input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Driver's License #	
Street address					City, State, Zip				
Phone (day)			Phone (evening, cell)			Email address			
Referred By		Race		Ethnicity		Primary Language			
Pharmacy Name		Pharmacy Address				Pharmacy Phone			
IN CASE OF EMERGENCY									
Emergency Contact				Relationship to patient					
Street address				City, State, Zip					
Phone (day)				Phone (evening, cell)					
INSURANCE INFORMATION									
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> PPC				<input type="checkbox"/> Worker's Comp <input type="checkbox"/> Auto Accident				Date of Injury / /	
Primary Insurance Name				WC or Auto Insurance Company					
Address				Address					
City, State, Zip				City, State, Zip					
Phone		Fax		Employer at time of injury					
Policy Subscriber Name				Address					
Patient's relationship to subscriber				City, State, Zip					
Subscriber ID# or Social Security #				Phone		Fax			
Plan Name				Claim #					
Policy #		Group #		Claim Adjuster					
Primary Care Physician				Phone		Fax			
Phone		Fax		Case Manager					
Secondary Insurance Name				Phone		Fax			
Address				Name of attorney					
City, State, Zip				Contact Person					
Policy #		Group #		Phone		Fax			
Phone		Fax		Lawsuit pending? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Policy Subscriber Name				Auto accident deductible: \$		Met? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient's relationship to subscriber				LIEN? <input type="checkbox"/> Yes <input type="checkbox"/> No		LOP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CO-PAY? \$		Self-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No							
EMPLOYMENT INFORMATION									
Employer				Occupation					
Street Address				City, State, Zip					
Phone		Fax		Email					

HEALTH HISTORY QUESTIONNAIRE

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

Patient Name: *Last* _____ *First* _____ *MI* _____

Today's Date: _____ **Reason for Visit:** _____

Previous or referring doctor: _____ **Patient sex :** M F **DOB:** _____

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

<input type="checkbox"/> AIDS/HIV +	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Gout	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> TB
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	LIST ANY OTHERS
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/>
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sexually Transmitted Disease	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Do you know your blood type? Yes No Type: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Drug Name	Strength	Frequency Taken
1			6		
2			7		
3			8		
4			9		
5			10		

Allergies to medications

Drug Name	Reaction You Had	Drug Name	Reaction You Had
1		3	
2		4	

Vaccines

Vaccine name	Date Received	Vaccine Name	Date Received
1		3	
2		4	

PATIENT NAME:	DOB:
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HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY) <small>ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.</small>
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Exercise	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	# of meals you eat in an average day?				
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/> Cigarettes – packs/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years: _____ <input type="checkbox"/> Or year quit: _____				
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Personal Safety	Do you live alone?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have frequent falls?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have vision or hearing loss?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

FAMILY HEALTH HISTORY

Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel depressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you panic when stressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have problems with eating or your appetite?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you cry frequently?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have trouble sleeping?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been to a counselor?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever attempted suicide?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

SCREENINGS (please indicate most recent date)			
Last Colonoscopy: / /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Cholesterol Screening: / /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Test for blood in stools: / /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Electrocardiogram: / /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

PATIENT NAME: _____ **DOB:** _____

Review Of Systems (check all that apply to you)

<p>CONSTITUTIONAL</p> <input type="checkbox"/> Wt. loss or gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills	<p>NEURO</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Headache <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Balance problems <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness	<p>GENITOURINARY</p> <input type="checkbox"/> Burning urination <input type="checkbox"/> Excessive urination <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent bladder/kidney infections <input type="checkbox"/> History of sexually transmitted disease	<p>RESPIRATORY</p> <input type="checkbox"/> Frequent lung infections <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest tightness <input type="checkbox"/> Wheezing <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Persistent cough <input type="checkbox"/> Asthma
<p>EYES</p> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Vision changes <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma	<p>PSYCH</p> <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Memory problems <input type="checkbox"/> Anxiety	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Incontinence of bowels <input type="checkbox"/> Blood in stools <input type="checkbox"/> Bloating <input type="checkbox"/> Poor appetite <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea	<p>CARDIOVASCULAR</p> <input type="checkbox"/> History of Rheumatic fever <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain <input type="checkbox"/> Swelling hands <input type="checkbox"/> Swelling feet <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> High or low blood pressure
<p>ENT/MOUTH</p> <input type="checkbox"/> Sinus problems <input type="checkbox"/> Runny nose <input type="checkbox"/> Tooth pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing ears <input type="checkbox"/> Gum pain <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge	<p>ENDO</p> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Hair loss <input type="checkbox"/> Nail changes <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot flashes	<p>HEM/LYMPH</p> <input type="checkbox"/> Bruising <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Lack of energy	<p>MUSC/SKELETAL</p> <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Muscle pains <input type="checkbox"/> Back pain <input type="checkbox"/> Pain during walking
<p>ALLERGY/IMMUNO</p> <input type="checkbox"/> Rashes/hives/welts <input type="checkbox"/> Itchiness <input type="checkbox"/> Allergic asthma/bronchitis	<p>SKIN</p> <input type="checkbox"/> Skin rashes <input type="checkbox"/> Bruising <input type="checkbox"/> Changes in skin lesions <input type="checkbox"/> Wounds <input type="checkbox"/> Ulcers		

WOMEN ONLY

Age at menstruation: / /	Date of last PAP smear: / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Number of pregnancies _____ Number of live births _____	Date of or age at last menstruation: / /
Last Mammogram: / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Bone Density Screening: / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last rectal exam? / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of times _____	
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last prostate and rectal exam? / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Date of last PSA test (if any): / / <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Is there anything else you would like to discuss with the doctor?

I have reviewed this history with the patient for accuracy and completeness:

Physician signature and date

Vinod Raxwal, MD

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PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)
 - I have I have NOT made a Living Will
- Health Care Surrogate
 - I have I have NOT designated a Health Care Surrogate
- Durable Power of Attorney
 - I have I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

PATIENT PRIVACY QUESTIONNAIRE

- I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____

Name: _____

Address: _____

Address: _____

Phone Number: _____

Phone Number: _____

Relationship: _____

Relationship: _____

- II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

- III. I understand that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL"

- IV. Confidential messages (i.e., appointment reminders) May May **not** be left on answering machine or voicemail.

- V. Please print the phone number where you want to receive calls about your appointments:

 I am fully aware that a cell phone is not a secure and private line.

PLEASE PRINT PATIENT NAME

DATE OF BIRTH

LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____, 20_____
TODAY'S DATE

Vinod Raxwal, MD

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CONSENT TO TREAT

I, the undersigned, voluntarily give consent to my Access Health Care Physicians, LLC medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Patient Printed Name Date: _____ DOB: _____

Signature of Patient/Legal Representative Relationship to Patient: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Access Health Care Physicians, LLC Notice of Privacy Practices and the Florida Patient Bill of Rights.

Signature of Patient/Legal Representative Date: _____

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my Access Health Care Physicians, LLC practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Access Health Care Physicians, LLC (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

Signature of Patient/Legal Representative Date