NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

Kenneth R. Barmach, MD
Lillian E. Cohn, MD
Allan L. Crimm, MD
Zuleika C. Font, MD
Kathryn Gruber, CRNP
Elizabeth M. Kinsella, CRNP
David A. Major, MD
Laura Oppenheim, MD
Gelsey L. Rellosa, MD
Arthur E. Smith, MD
David H. Verbofsky, MD

805 Locust Street
Philadelphia, PA 19107
(215) 440-8681
FAX (215) 440-9953

PATIENT HEALTH HISTORY FORM DIRECTIONS AND VISIT DAY INSTRUCTIONS

Dear Patient:

Prior to your Appointment:

Please complete all the attached forms and bring them with you on the day of your visit.

☐ If this box is checked, your provider wants you to get lab work drawn at least 4 business days prior to your appointment so that we can review the results with you in person. Based on the insurance information we have on file, an order is enclosed for the appropriate lab company. Please contact us if you need a revised order sent to a different company.

On the Day of your Appointment:

- Please do not wear any perfumes, lotions or oils, since they may interfere with an ECG tracing.
- If you have not had blood-work done prior to this appointment, please fast for 2 hours prior to your arrival.

Please note: if you cancel with less than 24 hours notice or do not show up for your appointment, you will be charged $50.00.

NINTH STREET INTERNAL MEDICINE PATIENT NAME: _____ DATE OF BIRTH: _____

APPOINTMENT DATE: _____

ESTABLISHED PATIENT COMPLETE PHYSICAL

What Chief Concern would you like to discuss with the Provider during your Physical today?

_____

_____

_____

How is your life in general?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Disastrous

Special Diet? _____

DO YOU HAVE ANY OF THE FOLLOWING?

Constitutional

Falls? ☐ Yes ☐ No

Fatigue? ☐ Yes ☐ No

Cardiology

Chest Pain? ☐ Yes ☐ No

Shortness of Breath? ☐ Yes ☐ No

Palpitations? ☐ Yes ☐ No

Leg Swelling? ☐ Yes ☐ No

Dermatology

Rash? ☐ Yes ☐ No

ENT

Nasal congestion? ☐ Yes ☐ No

Sore throat? ☐ Yes ☐ No

Hearing loss? ☐ Yes ☐ No

Post-nasal drip? ☐ Yes ☐ No

Dizziness? ☐ Yes ☐ No

Gastroenterology

Abdominal Pain? ☐ Yes ☐ No

Nausea? ☐ Yes ☐ No

Vomiting? ☐ Yes ☐ No

Heartburn? ☐ Yes ☐ No

Gastroenterology

Indigestion? ☐ ☐

Diarrhea? ☐ ☐

Constipation? ☐ ☐

Change in bowel habits? ☐ ☐

Blood in stool? ☐ Yes ☐ No

Hemorrhoids? ☐ Yes ☐ No

Hematology/Lymph

Bleeding problems? ☐ Yes ☐ No

Clotting problems? ☐ Yes ☐ No

Musculoskeletal

Joint Pain? ☐ Yes ☐ No

Back Pain? ☐ Yes ☐ No

Neurology

Headache? ☐ Yes ☐ No

Tingling/Numbness? ☐ Yes ☐ No

Visual Changes? ☐ Yes ☐ No

Memory Loss? ☐ Yes ☐ No

Smoking Status

Current ☐

Former ☐

Never ☐

Psychology

Anxiety? ☐ Yes ☐ No

Sleep disturbances? ☐ Yes ☐ No

Urology

Urinary frequency? ☐ Yes ☐ No

Urinary Urgency? ☐ Yes ☐ No

Blood in urine? ☐ Yes ☐ No

Urinary incontinence? ☐ Yes ☐ No

Kidney stone? ☐ Yes ☐ No

Exercise:

☐ Never ☐ Occasional ☐ 2-3 days per week ☐ 3-5 days per week ☐ Every Day

Does a partner from a current or past relationship make you feel unsafe?

☐ Yes ☐ No

Alcohol Use? Number of Drinks

☐ Daily ☐ Weekly ☐ Never

Any questions about sex you would like to discuss with your doctor?

☐ Yes ☐ No

Regular dental care?

☐ Yes ☐ No

Alcohol Use

NINTH STREET INTERNAL MEDICINE PATIENT NAME: _____ DATE OF BIRTH: _____

APPOINTMENT DATE: _____

ESTABLISHED PATIENT COMPLETE PHYSICAL

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If yes, How often? ☐ Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily

If yes, How many drinks did you have on a typical day this past year? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

If yes, how often did you have six or more drinks on one occasion in the past year?

☐ never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily

Recreational drug use? ☐ Yes ☐ No

Guns in the house? ☐ Yes ☐ No

Regular eye care? ☐ Yes ☐ No

Home smoke detector use? ☐ Yes ☐ No

Surgical History and Allergies Information

Please list any recent surgeries	Date	Please list any recent surgeries	Date

Please list any recent hospitalizations/urgent care visits that are not included in surgical history

Please list Hospital/Reason	Date	Please list Hospital/Reason	Date

Please list any allergy information if you have not already submitted it. Enter 'NONE' if there are no known allergies.

Allergic to [Drug/Non-Drug]	Allergic Reaction

Social History

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Number of People in Household:

☐ 1 ☐ 2 ☐ 3 ☐ 4+

Highest Education Level:

☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Grad School ☐ Post Graduate ☐ Other

Occupation: _____

Last Screening Tests (Include dates and name of provider or hospital):

Colonoscopy _____

Men Only - PSA (prostate cancer blood test) _____

Women Only - Pap Test/Name of GYN _____

Mammogram _____

DXA bone density scan _____

Name of Ophthalmologist _____

Diabetes only - Retinal Exam _____

Over 65 only - Glaucoma Screening by eye specialist _____

NINTH STREET INTERNAL MEDICINE PATIENT NAME: _____ DATE OF BIRTH: _____

APPOINTMENT DATE: _____

ESTABLISHED PATIENT
Insurance Information

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

ID# _____ GROUP # _____

GUARANTOR'S NAME: _____ DOB: _____

SECONDARY INSURANCE NAME: _____

ID# _____ GROUP # _____

GUARANTOR'S NAME: _____ DOB: _____

2016 HIPAA Privacy Authorization Form

NINTH STREET INTERNAL MEDICINE ASSOCIATES, INC.

Authorization for use or disclosure of protected health information. (Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)
Please list names and relationships of all persons that you authorize Ninth Street Internal Medicine Associates to release your medical information to during the course of your care:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I hereby authorize all medical sources to release and disclose the following protected health information to:

Ninth Street Internal Medicine Associate
805 Locust Street
Philadelphia, PA 19107
Phone: 215-440-8681
Fax: 215-440-9953

Specific information to be disclosed:	The information for which I'm authorizing disclosure will be used for the following purpose:
☐ Entire Medical Record Only information related to (specify): _____	☐ Further Medical Care
☐ Only the period of events from to(please describe):_____	☐ Personal Use
☐ Other: (please describe) _____ _____	☐ Other (please describe): _____ _____

Important Information About Your Rights

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to the Ninth Street Internal Medicine and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, NSIM cannot prevent re-disclosure by the recipient. I understand that any information disclosed in response to this request will NOT include information related to my treatment for AIDS/HIV, psychiatric care/treatment, treatment for drug/alcohol, unless I specifically consent to release of this information by checking any or all the boxes below:

☐ AIDS/HIV Information ☐ Psychiatric Care/Treatment ☐ Treatment for Drug and Alcohol use/abuse

_____ _____
Signature of Patient/Patient Representative Date of Signature

_____ _____
Printed Name of Patient/Patient Representative Relationship to Patient

_____ (Initial) I acknowledge that I have been provided a copy of Ninth Street's Internal Medicine's Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

_____ (Initial) I acknowledge that this authorization is only good for one calendar year.

PATIENT NAME: _____ **DATE:** _____
DOB

Medicare Annual Wellness Visit Self-Assessment Form

To us better identify your health risks and strategies to reduce them, please answer the following questions based upon how you have felt for the past 2 weeks.

1. Has your physical or emotional health limited your social activities with family or friends? **YES** **NO**
2. Are you able to eat, bathe, get dressed and get around in your home without help? **YES** **NO**
3. Are you able to prepare your own meals? **YES** **NO**
4. Are you able to do your own housekeeping without help? **YES** **NO**
5. Are you able to shop without help? **YES** **NO**
6. Can you handle your own money without help? **YES** **NO**
7. Are you able to travel independently by bus or taxi? **YES** **NO**
8. Are you in need of someone to help with chores, emotional support, or care in your home? **YES** **NO**
9. Do you drive a car? **YES** **NO**
   if yes: do you have difficulty driving **YES** **NO**
10. Do you have problems with your hearing? **YES** **NO**
11. Do you have trouble eating well? **YES** **NO**
12. Do you have trouble with your teeth or dentures? **YES** **NO**
13. Have you fallen two or more times in the past year? **YES** **NO**
14. Do you have difficulty with dizziness when standing up or problems with balance? **YES** **NO**
15. Are you afraid you will fall? **YES** **NO**
16. Do you have slippery rugs, bathtubs or clutter which might cause you to fall? **YES** **NO**
17. Do you have any urinary leakage or loss of bladder control? **YES** **NO**
18. Do you have difficulty taking medicine the way you are instructed? **YES** **NO**
19. How much pain do you have on a daily basis?
    (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)
20. How confident are you that you can control and manage most of your health problems?
    No health problems **Very** **Somewhat** **Not Very**
21. How often do you get the social & emotional support that you need?
    Always **Usually** **Sometimes** **Never**
22. How many days per week do you exercise? _____
23. When was your last dilated eye exam? _____
24. Name of your Eye Specialist _____

nsim 9th STREET INTERNAL MEDICINE
805 Locust St
Philadelphia, PA 19107
T: 215.440.8681 | F: 215.440.9953
MDVIP
www.nsimonline.com T: 215.940.9925 | F: 215.940.9928
Ninth Street Internal Medicine
805 Locust Street
PA19107-5507
Ph: 215-440-8681 Fax:215-440-9953 215-440-9953

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Trouble falling or staying asleep, or sleeping to much	0 ☐	1 ☐	2 ☐	3 ☐
2. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
3a. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
3b. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
6. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
7. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
8. Thoughts that you would be better off dead, or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

TOTAL: 0

9. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ☐
- Somewhat difficult ☐
- Very difficult ☐
- Extremely difficult ☐

Behavioural/Depression Project 5/19/04