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



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

ENT

Nasal congestion?
 Yes No

Sore throat?
 Yes No

Hearing loss?
 Yes No

Post-nasal drip?
 Yes No

Dizziness?
 Yes No

Gastroenterology

Indigestion?
 Yes No

Diarrhea?
 Yes No

Constipation?
 Yes No

Change in bowel habits?
 Yes No

Blood in stool?
 Yes No

Hemorrhoids?
 Yes No

Musculoskeletal

Joint Pain?
 Yes No

Back Pain?
 Yes No

Psychology

Anxiety?
 Yes No

Sleep disturbances?
 Yes No

Cardiology

Chest Pain?
 Yes No

Shortness of Breath?
 Yes No

Palpitations?
 Yes No

Leg Swelling?
 Yes No

Gastroenterology

Abdominal Pain?
 Yes No

Nausea?
 Yes No

Vomiting?
 Yes No

Heartburn?
 Yes No

Hematology/Lymph

Bleeding problems?
 Yes No

Clotting problems?
 Yes No

Neurology

Headache?
 Yes No

Tingling/Numbness?
 Yes No

Visual Changes?
 Yes No

Memory Loss?
 Yes No

Urology

Urinary frequency?
 Yes No

Urinary Urgency?
 Yes No

Blood in urine?
 Yes No

Urinary incontinence?
 Yes No

Dermatology

Rash?
 Yes No

Smoking Status

Current

Former

Never

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

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 _____

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

| | |
|---|--|
| <p>Specific information to be disclosed:</p> <p><input type="checkbox"/> Entire Medical Record Only information related to (specify): _____</p> <p><input type="checkbox"/> Only the period of events from to (please describe): _____</p> <p><input type="checkbox"/> Other: (please describe) _____</p> | <p>The information for which I'm authorizing disclosure will be used for the following purpose:</p> <p><input type="checkbox"/> Further Medical Care</p> <p><input type="checkbox"/> Personal Use</p> <p><input type="checkbox"/> Other (please describe): _____</p> |
|---|--|

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.