NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

Kenneth R. Barmach, MD
Lillian E. Cohn, MD
Allan L. Crimm, MD
Zuleika C. Font, MD
Marisa Gefen, MD
David A. Major, MD
Laura Oppenheim, MD
Gelsey L. Rellosa, MD
Arthur E. Smith, MD
Kathryn Gruber, CRNP

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

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

Please turn over and complete other side

ESTABLISHED PATIENT COMPLETE PHYSICAL

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 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 _____

2015 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): _____ ☐ Only the period of events from to(please describe):_____ ☐ Other: (please describe) _____ _____	☐ Further Medical Care ☐ Personal Use ☐ 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.