PATIENT HEALTH HISTORY FORM DIRECTIONS AND VISIT DAY INSTRUCTIONS

Prior to your Appointment:

STEP 1: Forms

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

STEP 2: Labs

Please have your labs drawn "at least" one week prior to your appointment if you would like to discuss your results at that time of you visit

PLEASE FAST for 12 hours before your labs.

~ **Enclosed** you will find your lab order which can be done prior to your visit.

Note: Labs for Wellness Exam can ONLY be drawn at the
QUEST DIAGNOSTICS 805 Locust Street, Philadelphia, PA, 19107
Hours are: Mon-Fri: 7:00am – 3:30pm
Office is closed for Lunch from 12:00 pm – 1:00 pm
MDVIP Membership Fee includes the cost of the labs.
*****If you take this lab slip to any other lab you WILL be charged an out of pocket fee.***

STEP 3: (optional) MDVIP Patient Portal

~ Available on the MDVIP portal is the *Interactive Health Assessment* that is a tool that will help you identify your health risks.

If you do not have a username & password and would like one, please contact:
MDVIP Corporate at 1-866-696-3847 or online @ connect.mdvip.com/request-registration-key

On the Day of your Appointment:

- Please do not wear any perfumes, lotions or oils, since they may interfere with an ECG tracing.

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New Patient Forms

Name:_____ **DOB:**_____

Date:_____

Please complete these forms in advance of your appointment and bring them with you. Thank You.

What **problems** do you wish to discuss with the doctor during your evaluation today?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have an Advance Directive? Yes / No

Please list any **NEW** allergies to medications**:** Drug / Reaction

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Surgical History:

Please list any surgeries from the last year	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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In the last few weeks have you had problems with any of the following?

Falls:	**( )Yes ( ) No**
Fatigue:	**( )Yes ( ) No**
Chest Pain:	**( )Yes ( ) No**
Sortness of Breath:	**( )Yes ( ) No**
Palpitations:	**( )Yes ( ) No**
Leg Swelling:	**( )Yes ( ) No**
Rash :	**( )Yes ( ) No**
Nasal Congestion:	**( )Yes ( ) No**
Sore Throat:	**( )Yes ( ) No**
Hearing Loss:	**( )Yes ( ) No**
Post Nasal Drip:	**( )Yes ( ) No**
Dizziness:	**( )Yes ( ) No**
Abdominal Pain:	**( )Yes ( ) No**
Nausea:	**( )Yes ( ) No**
Vomiting:	**( )Yes ( ) No**
Heart Burn:	**( )Yes ( ) No**
Indigestion:	**( )Yes ( ) No**
Diarrhea:	**( )Yes ( ) No**
Constipation:	**( )Yes ( ) No**
Change in Bowel Habits:	**( )Yes ( ) No**
Blood in Stool:	**( )Yes ( ) No**
Hemorrhoids:	**( )Yes ( ) No**
Bleeding Problems:	**( )Yes ( ) No**
Clotting Problems:	**( )Yes ( ) No**
Joint Pain:	**( )Yes ( ) No**
Back Pain:	**( )Yes ( ) No**
Headache:	**( )Yes ( ) No**
Tingling/Numbness:	**( )Yes ( ) No**
Sleep Problems:	**( )Yes ( ) No**
Visual Changes:	**( )Yes ( ) No**
Memory Loss:	**( )Yes ( ) No**
Anxiety:	**( )Yes ( ) No**
Sleep Disturbances:	**( )Yes ( ) No**
Urinary Frequency:	**( )Yes ( ) No**
Urinary Urgency:	**( )Yes ( ) No**
Blood in Urine:	**( )Yes ( ) No**
Urinary Incontinence:	**( )Yes ( ) No**
Kidney Stones:	**( )Yes ( ) No**

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Social History

Please answer the following questions.

What is your Marital Status? () Single () Married () Partnered () Divorced/ Separated () Widowed

How many people in household? () 1 () 2 () 3 () 4 ()5+

Highest education level? () High School () College () Graduate

Do you use recreational drugs? () Yes () No

Are there guns in your home? () Yes () No

Do you have a working smoke detector at home? () Yes () No

Do you exercise? () Never () Occasional () 1-2 Days a week () 3+ Days a week

Any questions about sex that you would like to discuss with the doctor? () Yes () No

Do you have regular eye care? () Yes () No

Do you have regular dental cleanings? () Yes () No

Are you on a special diet? () Yes () No

Have you've been a victim of abuse? () Yes () No

How is life in general? () Disastrous () Fair () Good () Very Good () Excellent

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MDVIP LONG LIVE HEALTHY

Burns Checklist ~ PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

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

Beck Index

How much you have been bothered by each symptom in the past week, including today....	~ 0 ~ None Not at all	~ 1 ~ Mildly Didn't bother me much	~ 2 ~ Moderately Unpleasent, but could stand it	~ 3 ~ Severely Could barely stand it
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of the worst happening				
Dizzy or lightheaded				
Heart pounding or racing				
Unsteady				
Terrified				
Nervous				
Feelings of choking				
Hands trembling				
Shaky				
Fear of losing control				
Difficulty breathing				
Fear of dying				
Scared				
Indigestion or discomfort in abdomen				
Faint				
Face flushed				
Sweating (not due to heat)				

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MDVIP LONG LIVE HEALTHY

The CAGE and CAGE-AID Questionnaire

Do you drink alcohol?	◯ Yes	◯ No
Have you ever experimented with drugs?	◯ Yes	◯ No
In the last three months, have you felt you should cut down or stop drinking or using drugs?	◯ Yes	◯ No
In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	◯ Yes	◯ No
In the last three months, have you felt guilty or bad about how much you drink or use drugs?	◯ Yes	◯ No
In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?	◯ Yes	◯ No

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MDVIP LONG LIVE HEALTHY

For Medicare Patients Only Please

PATIENT NAME:_____**DATE:**_____

Medicare Annual Wellness Visit Self-Assessment Form

Please think about how you would answer the following questions based upon how you have <u>been doing in the past four weeks</u> Your answers will help you receive the best possible healthcare and allow us to identify areas in which we can help you best.

1. Has your physical or emotional health limited your social activities with family or friends? Yes No
2. Would you have someone to help you if you needed help with chores, emotional support, or care in your home? Yes No
3. Do you have difficulty traveling independently by bus or taxi? Yes No
4. Are you unable to prepare your own meals? Yes No
5. Are you unable to do your own housekeeping without help? Yes No
6. Do you have difficulty shopping without help? Yes No
7. Do you have difficulty handling your own money without help? Yes No
8. Do you need help eating, bathing, getting dressed and getting around in your home without help? Yes No
9. Do you drive a car? Yes No
   If yes: Do you have any difficulty driving Yes No
10. Have you have problems with your hearing? Yes No
11. Have you recently had trouble eating well? Yes No
12. Have you recently had 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 slippery rugs, bathtubs or clutter which might cause you to fall? Yes No
15. Do you have difficulty with dizziness when standing up or problems with balance? Yes No
16. Are you afraid you will fall? Yes No
17. Do you have difficulty taking medicine the way you are instructed? Yes No
18. Do you have any urinary leakage or loss of bladder control? Yes No
19. On a daily basis how much chronic pain do you have? ***no pain*** ***moderate pain*** ***severe pain***
20. How often do you get the social & emotional support that you need?

    Always ***Usually*** ***Sometimes*** ***Never***
21. How confident are you that you can control and manage most of your health problems?

    I have no health problems ***Very confident*** ***somewhat confident*** ***not very confident***
22. How many days per week do you exercise? _____
23. When was your last dilated eye exam? _____
24. Name of your Eye Specialist? _____

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Medicare Preventative Services Recommendations

- Mammogram every 1- 2 years for women until age 85
- Glaucoma screening with your optometrist or ophthalmologist every 2 years
- Vision screening as recommended by your eye care provider
- Diabetes screening every year
- Cholesterol screening at least every 5 years
- Colonoscopy screening every 10 years until age 75 or more frequently as recommended
- Influenza vaccine yearly
- Shingles vaccine once after age 60 (This may or may not be covered by Medicare part D depending upon insurance coverage purchased by patient)
- Pneumonia vaccine once after age 65 (This is covered by Medicare)
- Tetanus /pertussis/diphtheria booster once after age 65 and every 10 years (This is NOT paid for by Medicare and is an additional cost to the patient)
- DEXA scan screening for osteoporosis in women after age 65 and in high risk men after age 70
- Stop Smoking
- Decrease Alcohol
- Exercise for 30 minutes or more 3 times a week
- Lose Weight
- Dietary Recommendations:
    - Make one half your plate fruits and vegetables
    - Make at least half your grains whole
    - Choose foods and drinks with little or no added sugars
    - Look out for salt (sodium) in foods you buy
    - Eat fewer foods that are high in saturated fats (animal fat, butter, cream, whole milk, stick margarine, coconut and palm oil
    - Eat the right amount of calories for you (get a personal daily calorie list at www.ChooseMyPlate.gov)
    - Use food labels to help make better food choices

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Medicare Preventative Services Recommendations Con't

HOME SAFETY

- In all living areas, avoid throw rugs and secure any loose carpet edges with nonskid tape.
- Make sure the floor is devoid of clutter and nightlights or motion-sensitive lighting are maintained throughout the home.
- Adding contrasting color strips to stairs aids in weakened depth perception and implementing grab bars and handrails helps with depreciated balance.
- Emergency numbers should be listed in large print by each phone. It's also smart to consider installing an electronic emergency response system, like LifeAlert.

MEDICATION SAFETY

- Know the names of your medicines.
- Complete a Medication List and keep the list updated. Take it with you on each visit to your doctor or pharmacist, and whenever you travel away from home.
- Take your medicines until they're gone. This is especially important for antibiotics. If you are prescribed two weeks' worth of pills, don't stop them in a few days "because you're feeling better." These medicines need to be taken for the total duration of time that they are prescribed to completely clear the infection and keep it from coming back.
- Don't mix pills in bottles with other pills. Keep them in their original container (unless you place them in a dispenser).
- Be alert for any side effects, especially when starting a new medicine or increasing the dose of an existing medicine. Any new symptom in an older adult should be considered a medicine side effect until proved otherwise. Check with your doctor or pharmacist if you have any questions or suspect that your medicine may be causing problems.
- Use one pharmacy for all your prescription medicines. This will reduce the chance that you will obtain conflicting medicines from different pharmacies.
- Ask your pharmacist's advice before splitting or crushing any pills. Some pills should only be swallowed whole and may produce dangerous effects if the pill is altered.
- Keep all medicines out of the reach of children.
- Discard any medicines that you are no longer taking. Having old medicines around the house increases the risk that you or a family member might take them by accident, or that a child might get into them. Keep your medicines securely stored in a safe place.

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Dear Patients:
We are implementing two very important elements of our electronic health record program;
The Patient Portal and access to the Complete Prescription Medication History.

The Patient Portal section of our electronic record will:

1. Provide you access to important elements of your medical record including:
•Medical summaries
•Lab results
•Visit summaries

2. Facilitate secure email communications for non-urgent issues including
•Prescription refill requests
•Referral requests
•Appointment requests
•Non-urgent messages to and from your care team

If you rarely check your email please DO NOT enable the portal.

PLEASE NOTE: Response time for portal messages is 2 business days.
FOR URGENT ISSUES REQUIRING SAME DAY ATTENTION; PLEASE CALL THE OFFICE DIRECTLY.

PATIENT PORTAL ACCESS REQUEST

I request that NSIM provide me with access to the secure Patient Portal so that I can view portions of my medical record and send and receive non-urgent secure messages regarding my health records, laboratory tests, and appointments.

If you do not wish to take advantage of this service, please check here. ☐

Print Email Address: _____

_____ _____
Print Patient Name **DATE OF BIRTH**

_____ _____
Patient Signature **Date**

The Complete Prescription Medication History section of our electronic record will:

- Have up-to-date information about all prescriptions given to you by all of your providers.
- Prevent adverse medication interactions.
- Our providers here at NSIM will be the only providers with access.

CONSENT TO OBTAIN MY COMPLETE PRESCRIPTION MEDICATION HISTORY

I authorize NSIM to view my external prescription history. My signature certifies that I have read and understand the scope of my consent and that I authorize access to my prescription medication history.

If you do not wish to take advantage of this service, please check h ☐

_____ _____ _____
Print Patient Name **Patient Signature** **Date**

_____ _____
Witness **Date**

CONTACT PREFERNCES

How would you prefer NSIM to contact you electronically for appointments reminders or to relay information?
(PLEASE CIRCLE ONLY ONE)

HOME PHONE ***EMAIL*** ***TEXT MESSAGE*** ***CELL PHONE***

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MDVIP LONG LIVE HEALTHY

AUTHORIZATIONS
ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Ninth Street Internal Medicine Associates, Ltd.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of patient or responsible party **Date**

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Ninth Street internal Medicine Associates Ltd for any services furnished me by Ninth Street Internal Medicine Associates, Ltd. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of related services.

_____ _____

Medicare Beneficiary Signature Date

_____ _____

Medicare Number Medigap Plan

In Compliance with Medicare regulation we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health benefits? ☐Yes ☐No

Are you entitled to Medicare because of disability or End Stage Renal Disease? ☐Yes ☐No

Is the illness of injury the result of an automobile accident or other injury? ☐Yes ☐No

Has treatment for the accident or illness been authorized by the Veterans Administration? ☐Yes ☐No

Are you entitled to any benefits under the Federal Black Lung Program? ☐Yes ☐No

I certify that this information is true and complete to the best of my knowledge

Signature_____ Date_____

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MDVIP | LONG LIVE HEALTHY

ACKNOWLEDGEMENT OF HEALTH INFORMATION PRACTICES

I, _____ acknowledge receiving a copy of the
Name
office's privacy notice. I have read it and I understand how my private health information will be used, and who will have access to it. I also understand that when the office discloses health information for any purpose outside of treatment, payment, and health care operations, it will require my signature in the form of a formal authorization.

Please list the family members or other persons with whom we may discuss your general medical condition:

_____ _____
Name Relationship

_____ _____
Name Relationship

Please list the additional family members or other persons with whom we may discuss your medical condition **ONLY IN AN EMERGENCY:**

_____ _____
Name Relationship

_____ _____
Name Relationship

Please indicate if you want all correspondence from this office sent to your home address
YES_____NO_____
Alternate address if not home:

_____
_____
_____

Please indicate the telephone # you wish us to use to contact you _____ May we leave a message on an answering machine/voice mail? YES_____NO_____

Date_____ Signature _____

Please note: We are only allowed to communicate about you with individuals listed on this sheet, so please list all appropriate names and tell us if you need to update the list.

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