NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

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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.

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: _____

PATIENT NAME: _____ **DATE:** _____

DOB: _____

Annual Wellness Visit Self-Assessment Form

FALLS RISK

1	Have you fallen two or more times in the past year?	**YES**	**NO**	
	If yes were you injured?	**YES**	**NO**	
2	Do you have difficulty with dizziness or problems with balance?	**YES**	**NO**	
3	Do you avoid doing things due to the fear of falling?	**YES**	**NO**	
4	Do you have things in your house which might cause you to fall?	**YES**	**NO**	

PHYSICAL ACTIVITY AND PAIN

1	How often does physical/emotional health interfere with your daily activities?	**Frequently**	**Occasionally**	**Almost never**
2	How often do you take the escalator over the stairs?	**Frequently**	**Occasionally**	**Almost Never**
3	How often does pain interfere with your normal activities?	**Frequently**	**Occasionally**	**Almost never**
4	How much pain do you have on a daily basis?	**0 1 2 3 4 5 6 7 8 9 10**		
	If you do have daily pain, where is the pain located? _____			
5	Approximately how many days each week are you physically active?	**0-1 days**	**2-3 days**	**4 or more**
6	How many days a week do you exercise?	**0-1 days**	**2-3 days**	**4 or more**
7	How many hours of sleep do you usually get each night?	**5 or less hours**	**6-7 hours**	**8 or more hours**

ACTIVITIES OF DAILY LIVING

1	Can you eat, bathe, get dressed, get around your home without help?	**YES**	**NO**	
2	Are you able to prepare your own meals?	**YES**	**NO**	
3	Are you able to do your own housekeeping without help?	**YES**	**NO**	
4	Are you able to shop without help?	**YES**	**NO**	
5	Can you handle your own money without help?	**YES**	**NO**	
6	Are you able to travel independently by bus or taxi?	**YES**	**NO**	
7	Do you have enough help at home with your care or doing chores?	**YES**	**NO**	
8	Do you drive a car?	**YES**	**NO**	
	If yes: do you have any difficulty driving?	**None**	**Some Difficulty**	**Very Difficult**

OTHER HEALTH ISSUES

1	When was your last dilated eye exam? _____			
	Name of your eye doctor: _____			
2	Do you have problems with your hearing?	**YES**	**NO**	
3	Do you have problems with your memory?	**YES**	**NO**	
4	Do you have trouble eating well?	**YES**	**NO**	
5	Do you have trouble with your teeth or dentures?	**YES**	**NO**	
6	Do you have a Living Will?	**YES**	**NO**	
	If yes, have you given us a copy?	**YES**	**NO**	
7	Did you get a flu shot this year?	**YES**	**NO**	
	If not do you want one?	**YES**	**NO**	

PLEASE TURN PAGE OVER

PATIENT NAME: _____ **DATE:** _____

DOB: _____

Annual Wellness Visit Self-Assessment Form

BLADDER CONTROL

1	Is leaking of urine a problem for you?	**YES**	**NO**	**N/A**
2	Has urine leakage changed your activities or interfered with sleep?	**YES**	**NO**	**N/A**
3	If urine leakage is a problem for you, would you be willing to try:			
	Medications	**YES**	**NO**	
	Bladder Training Exercises	**YES**	**NO**	
	Surgery	**YES**	**NO**	

MEDICATIONS

Remembering to take your medications can sometimes be challenging.

1	How often did you miss taking one or more of your medication in the last 2 weeks?	**Almost never**	**Occasionally**	**Frequently**
2	Are you unsure/confused about what your medications are for?	**YES**	**NO**	**N/A**
3	Are you unsure/confused about how or when to take your medications?	**YES**	**NO**	**N/A**
4	Are you unsure/confused about why you need to take your medications?	**YES**	**NO**	**N/A**
5	Do you have any medications your cannot afford?	**YES**	**NO**	**N/A**
6	Do you have trouble getting your medications due to the inability get to the pharmacy or the inability to have them delivered?	**YES**	**NO**	**N/A**
7	Do you have concerns/questions about your medication's side effects?	**YES**	**NO**	**N/A**
8	Do you have difficulty taking medicine the way you are instructed?	**YES**	**NO**	**N/A**

ISSUES EFFECTING YOUR HEALTH

1	In the past year, was there a time when you couldn't afford to see a doctor?	**YES**	**NO**		
2	Are you worried at times you cannot get your medicine due to expenses?	**YES**	**NO**		
3	Do you ever eat less because there isn't enough food?	**YES**	**NO**		
4	Are you worried that in the next few months you may not have housing?	**YES**	**NO**		
5	Do you feel your safety is threatened in your home?	**YES**	**NO**		
6	In the past year, have you had a hard time paying your utility bills?	**YES**	**NO**		
7	Do you feel like it is a hardship to obtain household supplies?	**YES**	**NO**		
8	Do you have any problems with access to transportation to get to your medical appointments?	**YES**	**NO**		
9	Do you need a translator to communicate with your provider?	**YES**	**NO**		
10	Do you have difficulty learning about your medical condition from the information given to you or what is told to you?	**YES**	**NO**		
11	Do you miss having people around you?	**YES**	**NO**		
12	Do you receive enough support from family and friends?	**ALWAYS**	**USUALLY**	**SOMETIMES**	**NEVER**
13	How confident are you that you can control and manage most of your health problems?	**VERY**	**SOMEWHAT**	**NOT VERY**	**N/A**

SATISFACTION WITH ACCESS

1	In the past 12 months, how often did you get an appointment in the amount of time you felt was appropriate?	**ALWAYS**	**USUALLY**	**SOMETIMES**	**NEVER**
2	In the past 12 months, how satisfied are you with the care or treatment you received in this office?	**VERY**	**SOMEWHAT**	**NOT VERY**	**N/A**

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Ninth Street Internal Medicine Associates
805 Locust Street
Philadelphia, PA 19107

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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 Life Alert®

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.

nsim 9th STREET INTERNAL MEDICINE

Patient's Name _____

Medicare Preventative Services Recommendations for You

- ☐ 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 (Pneumoccal-23) once after age 65 (This is covered by Medicare)
- ☐ Other Pneumonia vaccine (Prevnar-13) 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 your personal daily calorie limit at www.ChooseMyPlate.gov)
  - Use food labels to help you make better food choices

nsim 9th STREET INTERNAL MEDICINE

2020 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 Date of Birth

_____ _____
Printed Name of Patient Date of Signature

_____ (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.

2020 HIPAA Privacy Authorization Form

NINTH STREET INTERNAL MEDICINE ASSOCIATES, LTD.

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**_____