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.
### 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?
- [ ] Yes
- [ ] No

### DO YOU HAVE ANY OF THE FOLLOWING?

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>ENT</th>
<th>Gastroenterology</th>
<th>Musculoskeletal</th>
<th>Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Fatigue?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Cardiology</th>
<th>Neurology</th>
<th>Urology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain?</td>
<td>Headache?</td>
<td>Urinary frequency?</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Shortness of Breath?</th>
<th>Tingling/Numbness?</th>
<th>Urinary Urgency?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
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<tr>
<td>[ ] No</td>
<td>[ ] No</td>
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<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
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<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Leg Swelling?</th>
<th>Memory Loss?</th>
<th>Kidney stone?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
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<tr>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastroenterology</th>
<th>Dermatology</th>
<th>Smoking Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain?</td>
<td>Rash?</td>
<td>Current</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
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<tr>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nausea?</th>
<th>Bleeding problems?</th>
<th>Former</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
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<tr>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Vomiting?</th>
<th>Clotting problems?</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
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<tr>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
</table>

### Exercise:
- [ ] Never
- [ ] Occasional
- [ ] 2-3 days per week
- [ ] 3-5 days per week
- [ ] Every Day

### Alcohol Use
- [ ] Yes
- [ ] No

### Does a partner from a current or past relationship make you feel unsafe?
- [ ] Yes
- [ ] No

### Alcohol Use?
- [ ] Daily
- [ ] Weekly
- [ ] Never

### Any questions about sex you would like to discuss with your doctor?
- [ ] Yes
- [ ] No

### Regular dental care?
- [ ] Yes
- [ ] No
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 hospitalizations/urgent care visits that are not included in surgical history

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
### Insurance Information

**Primary Insurance Name:**

ID# ___________________________   GROUP # ___________________________

GUARANTOR'S NAME: ___________________________   DOB: ___________________________

**Secondary Insurance Name:**

ID# ___________________________   GROUP # ___________________________

GUARANTOR'S NAME: ___________________________   DOB: ___________________________
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:

☐ Entire Medical Record
☐ Only the period of events from to (please describe):_______________________________
☐ Other: (please describe) ___________________

The information for which I’m authorizing disclosure will be used for the following purpose:

☐ 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)  ____________________________ (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