PATIENT HISTORY FORM

Name:_____ Date:_____ Phone #: _____

Address:_____

Social Security #: _____ Cell/Work#:_____

DOB: _____ Marital Status: _____ Occupation:_____

Insurance Co:_____ ID#: _____

_____

Referring Physician:_____

Reason for coming:_____

Ever hospitalized for illness or surgery: _____Yes _____No

Surgeries: _____

Medications: _____

_____

Medication Allergies:_____

Family History: Any family history of congenital heart disease, heart attack, stroke, hypertension, high cholesterol, diabetes, cardiac arrhythmia, sudden death, obesity, cancer.

Father_____

Mother_____

Brother_____

Sister_____

Children_____

Have you experienced any of the following symptoms: (circle)

- Chest pain/heaviness/tightness or burning.
  Shoulder/arm/jaw or back pain.
  Shortness of breath when lying flat or with exertion.
  Excessive perspiration, nausea, tiredness or fatigue.
  Leg pain or cramping with activity or at rest, especially at nighttime.
  Sensing your heart beating very fast, irregularly, feeling skipped beats or palpitations.
  Dizziness, lightheadedness, loss of consciousness, fainting or passing out.

Do any of the above symptoms occur with any of the below situations:

Walking fast, especially uphill or upstairs. Sitting or lying down. In cold weather. With emotional stress. Before or after eating. With change in position. Awaken you from sleep. During or after sexual relations.

Are the symptoms relieved with:

Rest
Change in position
Eating, drinking or taking antacids
Rubbing the chest
Nitroglycerin

Have you ever had any of the following: (circle)

Heart attack treated with thrombolytic (clot-busting) medications, stent or surgery.
Heart failure treated with medication, bi-V pacemaker, transplant.
Enlarged heart (cardiomyopathy)
Heart murmur or leaky heart valve, rheumatic fever
Abnormal electrocardiogram (EKG)
Abnormal echocardiogram
Abnormal stress test
Cardiac catheterization or angiogram
Coronary angioplasty or stent
Coronary artery bypass surgery
Heart valve replacement or repair
Heart valve infection or endocarditis
Repair of hole in heart (Atrial or Ventricular septal defects)
Pericarditis or pericardial window
Carotid artery disease requiring stent or surgery
Thoracic or abdominal aortic aneurysm or dissection with placement of endograft (stent) or surgery
Peripheral vascular disease of legs requiring stent or surgery
Subclavian or renal (kidney) artery stenosis with surgery or repair
Cardiac arrhythmia (atrial fibrillation, supraventricular tachycardia, ventricular tachycardia) requiring medication, EPS (electrophysiological study), ablation, pacemaker or implantable defibrillator.
Stroke treated with thrombolytic (clot busting) medication, stent or surgery.

Do you have or had any of the below problems: (circle)

High blood pressure
High cholesterol
Low HDL (good cholesterol)
Elevated triglycerides
Elevated homocysteine level
Elevated CRP level
Impaired kidney function
Kidney artery narrowing requiring stent or surgery
Severe kidney disease requiring dialysis
Kidney stones
Urinary tract infections
Bladder dysfunction, incontinence
Enlarged prostate or cancer
Peptic ulcer disease
Colitis, colon polyps, colon cancer; had upper endoscopy or colonoscopy
Gallbladder disease
Liver disease
Hepatitis B or C
Pancreatitis
Hemorrhoids
Diabetes – Neuropathy, Retinopathy (eye disease), foot ulcers
Lung disease – Asthma, emphysema, bronchitis, bronchiectasis, pneumonia, steroid or oxygen requiring, TB, lung cancer
Sleep Apnea
Thyroid disease
Parathyroid disease
Blood disorder – anemia, leukemia, past blood transfusion
Stroke, seizure disorder, pituitary disorder
Cataracts, macular degeneration, glaucoma
Osteoporosis
Varicose veins, past deep vein phlebitis, placement of IVC umbrella or filter to prevent blood clots to lung, past pulmonary embolism.
Skin disease, psoriasis, shingles
Sinus problems, seasonal allergies
Hearing aide
Arthritis – Osteoarthritis, rheumatoid arthritis, gout, neck or back surgery, hip fracture, hip or knee replacements
Loss of libido (sexual desire)
Erectile dysfunction

Smoking History:

Did you ever smoke? _____Yes _____No

How many years_____.

How many cigarettes, packs, cigars, pipe or other?_____

When did you quit?_____

Alcohol

Do you drink alcohol? _____Yes _____No

Liquor, wine or beer?

How many ounces, glasses or cans?_____

Exercise

Do you exercise? _____Yes _____No

How often weekly?_____ How much time each session_____

Diet

Do you attempt to eat healthy? _____Yes _____No

Low fat, carbohydrates (sugar), salt or calorie.

Any particular diet? _____South Beach _____ Atkins _____Other

Current weight_____ Goal weight_____

Caffeine: (circle)

Coffee, tea or caffeinated drinks, chocolate.

How much per day_____

Women

Last menstrual cycle _____

Age at menopause_____

# of pregnancies_____ # of children_____

Type of deliveries _____ vaginal _____C-section

During any of the pregnancies was there fluid retention, high blood pressure, diabetes, pre-eclampsia or eclampsia during any pregnancies.

Last pap smear result_____.

Last mammogram result_____.

Last bone density result_____.

Men

Last digital prostate exam_____.

Last PSA level_____.

Enlarged prostate or cancer?

Loss of libido or erectile dysfunction.

Use of Viagra, Levitra or Cialis. _____Yes _____No.

Last chest xray _____. Result:_____.

Last sigmoidoscopy or colonoscopy:

Normal/polyps/diverticulosis/colitis/other.

Name of gastroenterologist:_____.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI". It includes information that can be used to identify you that we've created or received about your past, present and future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose your PHI. With some exceptions we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy at any time. Any changes will not apply to the PHI we already have. Before we make any important changes to our policies, we will promptly change this notice and will post a new notice at the following locations in this office:

1. Front desk.
2. Each exam room.
3. Each treatment room.
4. Exiting desk.

You can also request a copy of this notice from the person listed below.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI).

We use and disclose information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures, as well as give you some examples.

A. Uses and disclosures relating to treatment, payment or health care operations that do not require your prior written consent. We may use and disclose your PHI without your consent for the following reasons:

Treatment: We may disclose your PHI to physicians, nurses and other health care personnel who provide you with healthcare services or who are involved with your health care. For example, if you are a diabetic, we may disclose your PHI to the DME company to provide you with the medically needed supplies and medications.

To obtain payment for treatment: We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the services and items provided to you. We reserve the right to disclose your information to our business associates, such as billing companies, claim processing companies, collection agencies and others that process our health care claims.

For healthcare operations: We may use your PHI in order to evaluate the quality of health care that you are receiving. We may also provide your PHI to our accountants, attorneys, consultant and other in order to make sure we complying with the laws that affect us.

C. The right to get a list of the disclosures we have made. You have the right to get a list of all instances in which we have disclosed your PHI. The list will not include uses or disclosures such as those made for treatment, payment or healthcare operations, or any other disclosure that is required as described above. We will respond to your request within 60 days of receiving your request in writing.

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights or you disagree with a decision we made about your access to your PHI, you may file a complaint with the person listed in the section below. You may also send a written complaint to the Secretary of the Department of Health and Humans Services (www.hhs.gov/ocr.hipaa). We will take no retaliatory action against you if you file a complaint about our privacy practices.

V. PERSONS TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Jamie Sacher or Sandra Kugler

By signing below, you have indicated that you have read and understand this notice and the rights that you have. Please select one of the options below.

_____I authorize Michael Sacher, DO and any of his employees to disclose my PMI to the following person or persons:

Name(s): _____

Address(es): _____

_____

Phone Number(s): _____

I understand that I can request changes to this authorization at any time.

_____ At this time, I request that my PHI be used only as described above and that it not be disclosed to any other person or persons except as needed for treatment, health care operations or payment as described above. I understand that I can request changes to this authorization at any time.

_____ _____

Patient Name Date

Assignment of Benefits: Please sign below to allow the office of Dr. Michael Sacher to bill your medical insurance.

I authorize the release of any medical or other information necessary to process all medical claims. I also request payments of government benefits either to myself or to the party who accepts assignment below.

Patient or authorized signature: _____ Date_____

I authorize the payment of medical benefits for services rendered to the providers of Michael Sacher, DO, PC.

Patient or authorized signature: _____ Date_____