CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

ADULT HEALTH HISTORY FORM

Name____**Date of Birth**_______________**Today's Date**_______________

MEDICATIONS ☐ I do not take any medications

Please list all medications including non-prescription drugs, vitamins, and over the counter medicine

Name of Medicine	Dose	How Often Taken

ALLERGIES ☐ No Allergies

Allergy	Reaction

What other Doctors do you see?____

When did you last have a complete physical exam?____

Dentist____Last exam____

Eye Doctor____Last eye exam____

Have you had any recent blood work? ☐Yes ☐No When_______________Where_______________

Flexible sigmoidoscopy or colonoscopy?* ☐ Yes ☐ No When_______________Where_______________

DEXA (bone density) test* ☐ Yes ☐ No When_______________Where_______________

Are you up to date on your immunizations? ☐ Yes ☐No When_______________Where_______________

Last Tetanus booster*_______________Last Flu shot*_______________Last Pneumovax*_______________

WOMEN

Date of last period_________________________ Number of pregnancies__________ Number of miscarriages__________

Menopause: ☐ Yes ☐ No *Date:*__________ Number of deliveries: Vaginal______ C-Section _______

Hysterectomy: ☐ Yes ☐ No *Date:*__________ Birth control method_________________________

Self-breast exam: ☐ Yes ☐ No *Date:*__________ Date of last Mammogram_________________________

Date of last Pap Smear_________________________

INFECTION EXPOSURE

☐ Yes ☐ No ☐ Unsure Are you concerned you might have HIV?

☐ Yes ☐ No ☐ Unsure Do you feel you are at risk for HIV based on blood transfusion before 1990, injection drug use or sexual preference?

☐ Yes ☐ No ☐ Unsure Have you had intimate contact with someone known to have HIV or other STD's?

☐ Yes ☐ No ☐ Unsure Are you concerned you might have hepatitis?

Patient Name________________________________

REVIEW OF SYSTEMS

Family Medicine / Internal Medicine

CONSTITUTIONAL ☐None
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise (general unwellness)
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

HEENT ☐None
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Visual changes

RESPIRATORY ☐None
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

CARDIOVASCULAR ☐None
- ☐ Chest pain
- ☐ Claudication (cramping in legs)
- ☐ Edema (leg swelling)
- ☐ Palpitations

GASTROINTESTINAL ☐None
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY ☐None
- ☐ Dysuria (painful urination)
- ☐ Hematuria (blood in urine)
- ☐ Polyuria (excessive urination)
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention (inability to urinate)

INTEGUMENTARY ☐None
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Hair loss
- ☐ Hirsutism (excessive hair growth on face and body)
- ☐ Hives
- ☐ Pruritus (severe itching of the skin)
- ☐ Mole changes
- ☐ Rash
- ☐ Skin lesion

NEUROLOGICAL ☐None
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance (unusual problems when walking)
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors

METABOLIC / ENDOCRINIC ☐None
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia (excessive thirst)
- ☐ Polyphagia (excessive hunger)

MUSCULOSKELETAL ☐None
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain

HEMATOLOGIC / LYMPHATIC ☐None
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Lymphadenopathy (swollen lymph nodes)

IMMUNOLOGIC ☐None
- ☐ Contact allergy
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

REPRODUCTIVE (FOR FEMALES) ☐None
- ☐ Abnormal pap smear
- ☐ Dysmenorrhea (painful menstruation)
- ☐ Dyspareunia (painful sexual intercourse)
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Vaginal discharge

REPRODUCTIVE (FOR MALES) ☐None
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Sexual dysfunction

PSYCHIATRIC ☐None
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Patient Name________________________________

MEDICAL HISTORY

☐ No Medical Problems

PROBLEM	DATE PROBLEM BEGAN	PROBLEM	DATE PROBLEM BEGAN
☐ Allergies*	____________	☐ Elevated Lipids*	____________
☐ Anemia*	____________	☐ Gallbladder Disease	____________
☐ Angina	____________	☐ GERD/Reflux	____________
☐ Anxiety	____________	☐ Headache, Migraine	____________
☐ Arthritis*	____________	☐ Heart Disease	____________
☐ Asthma*	____________	☐ Heart Valve Disorder	____________
☐ Atrial Fibrillation	____________	☐ Hepatitis / Liver Disease*	____________
☐ Benign Prostatic Hypertrophy	____________	☐ HIV / AIDS	____________
☐ Blood Clots/DVT	____________	☐ Hypertension	____________
☐ Cancer*	____________	☐ Irritable Bowel Syndrome	____________
☐ Cardiac Arrhythmia*	____________	☐ Lupus	____________
☐ Colon Polyps	____________	☐ Myocardial Infarction	____________
☐ Congestive Heart Failure	____________	☐ Osteoporosis	____________
☐ COPD	____________	☐ Renal Disease*	____________
☐ Coronary Artery Disease	____________	☐ Seizure Disorder	____________
☐ Depression	____________	☐ Sleep Apnea	____________
☐ Diabetes*	____________	☐ Stroke	____________
☐ Diverticulitis	____________	☐ Thyroid Disease	____________

Please list if you have any other Medical Problems not listed above; please include the Date that the Problem began:

____

____

____

____

SURGICAL HISTORY

☐ No Surgeries or Procedures

SURGERY/PROCEDURE	YEAR	SURGERY/PROCEDURE	YEAR
☐ Angioplasty*	____________	☐ Colectomy	____________
☐ Appendectomy	____________	☐ Colostomy	____________
☐ Arthroscopy* *Site*__________	____________	☐ Gastric Bypass	____________
☐ Back Surgery*	____________	☐ Hernia Repair	____________
☐ Bilateral Tubal Ligation	____________	☐ Hip Replacement *Side*____	____________
☐ Blood Transfusion	____________	☐ Hysterectomy*	____________
☐ Breast Augmentation	____________	☐ Knee Replacement *Side*____	____________
☐ CABG	____________	☐ LASIK	____________
☐ Cardiac Pacemaker	____________	☐ Mastectomy*	____________
☐ Carpal Tunnel Release	____________	☐ ORIF	____________
☐ Cataract Extraction	____________	☐ Thyroidectomy	____________
☐ Cholecystectomy	____________	☐ Tonsillectomy	____________

Please list if you have had any other Surgeries/Procedures not listed above; please include the Year:____________________

____

____

____

____

Patient Name________________________________

FAMILY HISTORY

☐ Adopted ☐ No Family History Known

ILLNESS/DISEASE	BLOOD RELATIVE	CAUSE OF DEATH	ILLNESS/DISEASE	BLOOD RELATIVE	CAUSE OF DEATH
☐ ADD/ADHD	______	______	☐ Diabetes*	______	______
☐ Alcoholism	______	______	☐ Glaucoma	______	______
☐ Allergies	______	______	☐ Hay Fever	______	______
☐ Alzheimer's Disease	______	______	☐ Heart Disease	______	______
☐ Arthritis*	______	______	☐ High Blood Pressure	______	______
☐ Asthma	______	______	☐ High Cholesterol	______	______
☐ Blood Disorder	______	______	☐ Irritable Bowel Syndrome	______	______
☐ Cancer Breast	______	______	☐ Mental Illness	______	______
☐ Cancer Colon	______	______	☐ Migraine	______	______
☐ Cancer Ovarian	______	______	☐ Obesity	______	______
☐ Cancer Prostate	______	______	☐ Osteoporosis	______	______
☐ Cancer Other*	______	______	☐ Renal Disease	______	______
☐ Cardiovascular Disease*	______	______	☐ Seizure Disorder	______	______
☐ Coronary Artery Disease	______	______	☐ Stroke	______	______
☐ Depression	______	______	☐ Thyroid Disease	______	______

Please list if there is any other Family History Illnesses or Diseases if not listed above; please include the Blood Relative and if it was the Cause of Death:____

____

____

____

____

SOCIAL HISTORY

Do you use Tobacco: ☐ No ☐ Yes ☐ Formerly

Tobacco Type: **Use Daily:** ☐
☐ Cigarettes ☐ Cigar ☐ Chewing
☐ Smokeless ☐ Pipe ☐ Snuff

Tobacco Usage Per Day: #_______ ☐ Units ☐ Packs
Years Used:___________ Age Quit:_____________

Do you drink Alcohol: ☐ No ☐ Yes ☐ Formerly

Alcohol Type: ______________

Date Quit: ___________

How Much: #______ Drinks / Glasses / Beers
How Often: ☐ Daily ☐ Weekly ☐ Monthly
☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially

Do you drink Caffeine: ☐ No ☐ Yes

Caffeine Type: ☐ Coffee ☐ Soda ☐ Tea ☐ Energy drinks

Caffeine per Day: #______ ☐ Cups ☐ Ounces

Do you use Recreational Drugs: ☐ No ☐ Yes ☐ Formerly

Drug Type: ______________

Drug Use Frequency: ☐ Daily ☐ Occasionally ☐ Weekly

Date Quit: ______________

Do you Exercise: ☐ No ☐ Yes

Exercise Type: ______________

Exercise Frequency: #________ Times per week
☐ Daily ☐ Occasionally ☐ Never

Occupation:________________________________

Employment Status:________________________________

Has Children: ☐ No ☐ Yes #______ Sons #______ Daughters

Marital Status: ☐ Single ☐ Married ☐ Life Partner
☐ Widow ☐ Divorced

CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

NAME(First, Middle, Last)____________________ ☐ MALE ☐ FEMALE

ADDRESS, CITY, STATE, ZIP CODE____________________

DATE OF BIRTH:_____/_____/_____ EMAIL ADDRESS____________________

HOME PHONE____________________ CELL PHONE____________________

May we leave a message? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No

PCP NAME____________________ REFERRING SPECIALIST____________________
(Primary Care Physician)

☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed NAME OF SPOUSE____________________

EMPLOYER NAME____________________ EMPLOYER PHONE NUMBER____________________

EMPLOYER ADDRESS____________________

EMERGENCY CONTACT INFORMATION:

NAME____________________ PHONE NUMBER____________________ RELATIONSHIP ____________________

Per CMS regulations we are required to ask for the following data. If you prefer not to share this information, please select the option 'I Decline'.

☐ I DECLINE TO REPORT

RACE
- ☐ AFRICAN AMERICAN
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER ____________________

ETHNICITY
- ☐ NOT HISPANIC OR LATINO
- ☐ HISPANIC OR LATINO

PREFERRED LANGUAGE:
- ☐ ENGLISH
- ☐ OTHER____________________

PRIMARY INSURANCE

INSURANCE NAME____________________

ID #____________________

GROUP #____________________

COPAY AMOUNT $____________________

ADDRESS____________________

PHONE #____________________

SUBSCRIBER NAME____________________

SUBSCRIBER'S DATE OF BIRTH_____/_____/_____

SUBSCRIBER'S EMPLOYER____________________

RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ CHILD

SECONDARY INSURANCE

INSURANCE NAME____________________

ID #____________________

GROUP #____________________

COPAY AMOUNT $____________________

ADDRESS____________________

PHONE #____________________

SUBSCRIBER NAME____________________

SUBSCRIBER'S DATE OF BIRTH:_____/_____/_____

SUBSCRIBER'S EMPLOYER____________________

RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ CHILD

INSURANCE AUTHORIZATION: I HEREBY AUTHORIZE CENTRAL ARIZONA MEDICAL ASSOCIATES TO FURNISH INFORMATION TO INSURANCE CARRIERS REGARDING MY ILLNESS AND TREATMENTS AND ALSO ASSIGN TO THE MEDICAL PROVIDERS PAYMENTS FOR MEDICAL SERVICES FOR MYSELF OR DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYMENTS, COINSURANCE AND DEDUCTIBLES.

NO-SHOW/LATE CANCELLATION POLICY: I UNDERSTAND THAT IN THE EVENT I AM UNABLE TO KEEP MY SCHEDULED APPOINTMENT, I MUST GIVE 24 HOURS NOTICE AND THAT FAILURE TO DO SO WILL RESULT IN A $25.00 FEE.

____________________ ____________________

PATIENT, PARENT, OR GUARDIAN SIGNATURE DATE

CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

PATIENT NAME:____

PART 1 – CONSENT TO APPOINTMENT REMINDERS:

Central Arizona Medical Associates partners with TeleVox® to provide appointment reminders via your telephone. As an added feature, you are able to confirm or cancel your appointment when you receive your appointment reminder. Please initial one of the selections below:

I CONSENT to receiving courtesy appointment reminders:

_________- Your Initials

OR

I PREFER NOT to receive courtesy appointment reminders:

_________- Your Initials

PART 2 – NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I am aware that Central Arizona Medical Associates is HIPAA compliant and that I was given the opportunity to review the Notice of Privacy Practices. I understand that I may request a written copy of the Notice of Privacy Practices at any time.

_______________________________ _______________________________

SIGNATURE **DATE**

PART 3 – DISCLOSURE OF YOUR HEALTH CARE INFORMATION:

This section allows you to decide who has access to discuss your Health Care Information, Treatment Plans, and Financial Billing Information or you may select that no one has access to your information. Please select one of the following and sign below.

_________ No one has access to my Health Care Information.

OR

________ I hereby grant permission to Central Arizona Medical Associates to discuss my Health Care Information with the following individual(s):

_______________________________ _______________________________

Name **Relationship**

_______________________________ _______________________________

Name **Relationship**

_______________________________ _______________________________

Name **Relationship**

_______________________________ _______________________________

SIGNATURE **DATE**

CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can obtain access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information.

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals' involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however if we do agree, we are bound by our agreement except otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical record and billing records, but not including psychotherapy notes. You must submit your request in writing to *Central Arizona Medical Associates / Dr. George Parides, Privacy Officer, 3638 E. Southern Ave Ste C108 - Mesa AZ 85206.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Central Arizona Medical Associates / Dr. George Parides, Privacy Officer, 3638 E. Southern Ave Ste C108 - Mesa AZ 85206.* You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Central *Arizona Medical Associates / Dr. George Parides, Privacy Officer, 3638 E. Southern Ave Ste C108 - Mesa AZ 85206*. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy policies, please contact *Dr. George Parides* at 480-834-0771.