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 Healthcare Providers 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_____

Menopause: ☐ Yes ☐ No *Date:*_____

Hysterectomy: ☐ Yes ☐ No *Date:*_____

Self-breast exam: ☐ Yes ☐ No *Date:*_____

Number of pregnancies_____ Number of miscarriages_____

Number of deliveries: Vaginal_____ C-Section _____

Birth control method_____

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 *Type*_____	_____	☐ 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 *Type*_____	_____	☐ 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

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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:_____

Children: ☐No ☐Yes #_____Sons #_____ Daughters

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

CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

New Patient

NAME _____ **DATE OF BIRTH** _____ **BIRTH SEX** ☐ Male ☐ Female
Please print your First Name Middle Initial Last Name

STREET ADDRESS _____ **APARTMENT/UNIT #** _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CELL PHONE _____ **HOME PHONE** _____
May we leave a message? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No

EMAIL ADDRESS Please print clearly _____

PRIMARY CARE PHYSICIAN First and Last Name _____

EMERGENCY CONTACT _____ **PHONE** _____ **RELATIONSHIP** _____

☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled ☐ Child | ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed

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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 _____

IS PATIENT A MINOR ☐ No ☐ Yes If yes, your First and Last name _____

YOUR RELATIONSHIP TO MINOR ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

PHARMACY _____ **CROSSROADS** _____/_____

MAIL-ORDER _____ **PHONE** _____

☐ Check here if you do not have medical insurance

PRIMARY INSURANCE_____

ID #_____

GROUP #_____

POLICY HOLDER NAME_____

POLICY HOLDER DATE OF BIRTH_____/_____/_____

RELATIONSHIP ☐ Spouse ☐ Parent ☐ Guardian ☐ Other_____

☐ Check here if you do not have secondary insurance

SECONDARY INSURANCE_____

ID #_____

GROUP #_____

POLICY HOLDER NAME_____

POLICY HOLDER DATE OF BIRTH_____/_____/_____

RELATIONSHIP ☐ Spouse ☐ Parent ☐ Guardian ☐ Other_____

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 $35.00 fee.

_____ _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE **DATE**

CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

PATIENT NAME:_____

PART 1 – 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.

_____ _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE **DATE**

PART 2 – DISCLOSURE OF HEALTH CARE INFORMATION:

This section is designated for you to list the name(s) of individual(s) who we may discuss Health Care Information, Treatment Plans, and Financial Billing Information with.
Please note, this does not give us permission or authorization to release your Health Care Records to the listed individual(s).

Check one of the boxes below:

☐ **I do NOT** grant Central Arizona Medical Associates permission to speak to anyone. I understand the representatives of Central Arizona Medical Associates will not speak to anyone on my behalf.

☐ **I grant** Central Arizona Medical Associates to discuss Health Care Information, Treatment Plans, and Financial Billing with the individual(s) listed below:

Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**

_____ _____

PATIENT, PARENT, OR GUARDIAN 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.