WINDSOR REGIONAL MEDICAL ASSOCIATES, LLC
CONFIDENTIAL HEALTH HISTORY

Filling out the following information is necessary for us to provide you with the best comprehensive care.

All of the information will be held in strict confidence.

For the convenience of our patients, please BE ADVISED that our office tries to run on schedule, so as a new patient you should arrive promptly at the time of your appointment with this paperwork completed.

If you are unable to complete these forms ahead of time, you are to arrive at least 15 minutes prior to your scheduled visit to complete them.

If you arrive late, or come at the time of your appointment without completed forms, you may be asked to reschedule. Thank you for your understanding.

Windsor Regional Medical Associates, LLC

PATIENT HISTORY

Name _____ Date of Birth _____ Date _____

Reason for today's visit _____

Prior/Other doctors you see _____

MEDICATIONS

List All Prescription AND non-prescription medications / supplements that you are taking

Drug	Drug Strength	Frequency

PAST MEDICAL HISTORY (Circle all that apply to you)

Eyes/Ears/Nose: – Glaucoma – Macular Degeneration - Cataracts - Hearing Loss - Nasal Allergies

Vascular: – High Blood Pressure - Heart Disease - Stroke - Diseases of the Veins - Rheumatic Fever - Murmur

Respiratory: – Asthma – Tuberculosis/Positive TB test - Emphysema/COPD - Pneumonia

GI tract: – Gallstones - Hepatitis - Ulcers - Acid Reflux Disease - Rectal Bleeding - Colon Polyps - Diverticulitis

Urinary: – Frequent Urinary Infections - Kidney Stones - Kidney Disease

Reproductive: – STD - Infertility - Enlarged Prostate - Erectile Dysfunction - Irregular Periods

Endocrine: – Diabetes - High Cholesterol/Triglycerides - Gland Disorder (thyroid, pituitary, adrenal, parathyroid)

Joints: – Osteoporosis - Arthritis - Rheumatoid Arthritis - Lupus - Gout - Psoriasis

Blood/Oncology: – Anemia - Blood Transfusion - Bleeding Disorder – DVT or clots – Cancer (type _____)

Nervous: – Frequent Headaches - Psychiatric Illness

Gynecology: # Pregnancies _____ # Deliveries _____ Date of last period _____

Other (Please describe)_____

***** LIST ALL FOOD OR DRUG ALLERGIES *****

_____

Surgeries (date, type, hospital)

Hospitalizations (date, type, hospital) and Serious Illnesses

FAMILY HISTORY

Family Member	Alive	Dead	Age	Diseases (e.g. cancer, heart disease, diabetes)
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Brothers/Sisters(age/health)				
Children(age/health)				

SOCIAL HISTORY (Circle Yes or No and fill in appropriate blank)

- Smoking: (Yes) (No) (In Past) Packs/Day _____ Years _____ Would you like to quit? _____
- Recreational Drug Use (past/present): No Yes - Drugs Used _____
- Exercise (Type/Frequency) _____
- Caffeine on a regular basis: No Yes Cups/Day _____
- Alcohol Intake: None Occasional 1-2 Drinks/Day More than 2 Drinks/Day
- Sexually Active: No Yes Number of Active Partners_____ Past Partners_____
- Have you traveled outside the US in the past 6 months? No Yes - Where?_____
- Occupation _____ Hazardous Exposures _____
- Do you need assistance caring for yourself? No Yes – Explain:_____

HEALTH SCREENING (write date last done)

Cholesterol _____ Bone Density _____ Blood Sugar_____ Blood Pressure Exam _____

Mammogram _____ Pap Smear _____ Colonoscopy _____ Chest X-ray _____ EKG_____

Stress Test _____ Rectal Exam _____ PSA test _____ Dentist _____ Eye Doctor _____

IMMUNIZATIONS (write year vaccine was given)

Pneumonia _____ Flu _____ Tetanus _____Hep B _____ Meningitis _____ Gardasil _____

REVIEW OF SYMPTOMS (**Circle** any symptoms you have experienced recently)

GENERAL: - weight gain - loss of appetite - fever - weakness - weight loss - night sweats

HEAD: - cold - cough - coughing blood - nose bleed - hearing loss - change in voice - sore throat
- ringing in ears - snoring

EYES: - diminished vision - eye irritation - drainage from eyes - blurred vision - allergic eyes - loss of vision

ENDOCRINE: - fatigue - excessive sweating - excessive thirst - excessive urination - weight loss
- cold intolerance - heat intolerance

ALLERGY: - runny nose - scratchy throat - itchy eyes - ear fullness - sinus congestion - stuffy nose

HEART: - chest pain - palpitations - leg swelling

LUNGS: - shortness of breath - pain with breathing - chest congestion

DIGESTIVE: - nausea - heartburn - stool incontinence - vomiting - bloating/belching - blood in stool
- difficulty swallowing - abdominal pain - diarrhea - constipation - change in bowel habits

URINARY: - difficulty urinating - blood in urine - urinary urgency - frequent urination - urinary incontinence
- genital pain - recurrent UTI - nighttime urination

SKIN: - rash - change in moles - lumps - dry/sensitive skin - hives

NERVOUS: - headache - tingling/numbness - seizures - insomnia - memory loss - dizziness - vertigo

BLOOD/GLANDS: - swollen glands - varicose veins - easy bruising

SKELETAL: - joint swelling - joint pain - muscle cramps - muscle pains - joint stiffness - trouble walking

PSYCHIATRIC: - high stress level - depression - sleep disturbances - overwhelming sense of panic
- suicidal thoughts - eating disorder - mental/physical abuse

MALE: - difficulty with erection - difficulty with ejaculation - diminished sexual drive - abnormal discharge

FEMALE: - heavy periods - pain with intercourse - premenstrual moodiness - pain with periods - infertility
- yeast infections - vaginal itching - bleeding between periods - irregular periods - abnormal discharge
- hot flashes - breast lumps - nipple discharge

Windsor Regional Medical Associates, LLC

Patient Information

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip _____

Home Phone ( )_____ SS # _____ Date of Birth _____

Work Phone ( ) _____ Cell Phone ( ) _____

Email: _____

Gender __Male __ Female __ Transgender **Race** __White __Black __Hispanic __Asian __American Indian __Other

Marital Status __Single __Married __Separated __Divorced __Widowed **Ethnicity** __Hispanic __ Non-Hispanic

Emergency Contact _____ Relationship _____ Phone ( )_____

How did you choose our office _____

May we leave messages for you at your home or on your mobile phone? __Yes __No

May we leave messages for you at work? __Yes __No

Pharmacy _____ Location _____ Phone ( )_____

Spouses Name _____ Spouses Work Phone ( ) _____ Ext_____

Do you have an advanced directive or living will? __ Yes __ No

Employment Information

Employed __Full Time __Part Time __Retired __No **Employer Name** _____

Street Address_____ City_____ State ____ Zip _____

Phone ( ) _____Ext _____ Occupation _____

Guarantor Information (Responsible Party for Bills) – If OTHER than Self

Guarantor's Name _____ **Relationship to Patient** __Spouse __Child __Other

If Child or Other – Please specify relationship of Other _____ and fill out the following information

Street Address_____ City _____State _____ Zip _____

Date of Birth _____ SS # _____

Home Phone ( ) _____Work Phone ( ) _____ Ext _____

Primary Insurance

Primary Insurance Name _____ Insured Name _____

Relationship to Patient __ Self __ Spouse __ Other Insured Date of Birth _____

Policy # _____ Group # _____

Secondary Insurance

Secondary Insurance Name _____ Insured Name _____

Relationship to Patient __ Self __ Spouse __ Other Insured Date of Birth _____

Policy # _____ Group # _____

Release of Records

I authorize the release of my medical information to the following other people:

_____ _____

If no one is listed, records will only be released to you or as required by law. **Please consider if you wish to allow family members any access to your information when completing this section.**

Patient's Payment Responsibility

I understand that I am financially responsible for all charges for all medical bills incurred while under the care of Windsor Regional Medical Associates, LLC including the balance remaining after payment of possible insurance benefits. In the event that my account is not paid, I shall be liable for any and all costs of collection, including but not limited to a fee of 40% of my outstanding balance if my account is forwarded to a collection agency or as allowed by law. I further understand that there will be a $10 per month service fee if my unpaid account balance is more than 30 days overdue. I understand that there will be a $20 service charge for any checks returned for insufficient funds. I understand that canceling a scheduled appointment with less than 24 hours notice or failing to show for a scheduled appointment in a timely manner may result in a cancellation fee of $50 per occurrence. My signature below indicates that I have read and understand the above terms and conditions.

Assignment of Benefits

I authorize payment of medical benefits directly to Windsor Regional Medical Associates, LLC on my behalf for all professional services rendered. I authorize Windsor Regional Medical Associates, LLC to submit claims to Medicare and/or other medical insurance carriers on my behalf. My refusal to sign indicates that I will be responsible for all charges I incur at the time services are rendered, and must seek third-party reimbursement independently. I further authorize that photocopies shall be valid as originals.

Release of Information

I authorize the release of any medical information necessary to process my claims or as required by law. I also authorize the release of prescription information to Windsor Regional Medical Associates, LLC from external sources.

Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Windsor Regional Medical Associates' Notice of Privacy Practices as required by federal law (HIPAA/HITECH Act).

I have read and agree to all statements, terms and conditions above.

_____ _____

Patient (and Parent/Guardian if Minor) Date