Medical History

Patient's Name (Last, First, MI): ________________________ **Date:** __________

Patient's Home Phone Number: ____________ **Cell Phone Number:** ____________

D.O.B.: ____________ **Age:** ____ **Sex:** M❑ or F❑ **Soc. Sec. #:** ____________

Address: ________________________ **City, State, Zip Code:** ____________

Reason for visit: ________________________

Marital Status: Married ❑ Single ❑ Divorced ❑ Widowed ❑

Employment Status: Full-Time❑ Part-Time❑ On-Call❑ Unemployed❑ Retired❑ Student❑ Other❑__________

Patient's Employer: ________________________

Race: Asian ❑ Black/African American ❑ Native American ❑ White/Caucasian ❑ Hispanic/Latino ❑ Other ❑

List other physicians that care for you (include previous primary care physician):

Name	Specialty	Location

Social History

Current smoker? Yes ❑ No ❑ **How many packs or cigarettes per day do you have?** __________

How many years have you smoked for? ________ **Former smoker?** Yes ❑ No ❑ **Year you quit:** ________

Illicit drug use? Yes ❑ No ❑ **Specify type:** ________________________

Alcohol Consumption? Yes ❑ No ❑ **How often?** Occasional ❑ Socially ❑ Weekly ❑ Daily ❑ Other ❑ ________

Do you exercise? Yes ❑ No ❑ **What activities do you do and how often?** ____________

Are you on any special diet? Yes ❑ No ❑ **If so, which one?** ____________

Do you consume caffeinated products? Yes ❑ No ❑ **If so, what and how much per day?** ____________

Do you have a living will? Yes ❑ No ❑ **If yes, please provide us a copy.**

Please list any allergies (medication, animals, food)**:**

Allergy	**Reaction** (rash, hives, shock)	**Severity** (mild, moderate or severe)

Family History

List any health conditions. If deceased, state cause of death and age.

Father: ______________________________

Mother: ______________________________

Siblings: ______________________________

Children: ______________________________

Medical Information:

Please list any medications you are currently taking, prescribed or over the counter (use the back of this page i needed):

Name	**Dose**	**Times Daily**	**Doctor Prescriber**	**Reason/Diagnosis**

List current medical conditions (HTN, DM, HLD, CVA, TIA, Anxiety, Depression, Cancer, Asthma, Anemia):

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

List any hospitalizations or surgeries (tonsillectomy, C-Section, Prostate, Cataract, Hernia, Appendectomy, Heary Hysterectomy). Include date if known:

Date	**Surgery**	**Complications** (Yes/No)

Have you ever had a reaction to Anesthesia? Yes ❑ No ❑ If yes, what happened? ___________________________
Have you had a blood transfusion? Yes ❑ No ❑ Any Reaction? Yes ❑ No ❑ If yes, what? ____________________
Do you have a bleeding tendency? Yes ❑ No ❑
Have you ever had any injuries? Yes ❑ No ❑ If yes, what type? ____
Have you ever had any infections? Yes ❑ No ❑ If yes, what? ____

Date of last complete physical exam (if known): ____
Date of last blood work (if known): ___________________ Date of last colonoscopy: ______________________

For Females:

Date of last menstrual period: _____________________ Date of last Pap Smear: __________________________
History of abnormal Pap (list date(s)) ______________________ Date of last Mammogram: ________________
Date of last DEXA (Bone) Scan: _______________
Number of pregnancies: __________ Miscarriages: ___________ Terminations: ________ Living Children: _______
Method (s) of Contraception: ____

Review of Systems

Check if you **currently** have any of the following:

❑ Fever	❑ Chills	❑ Fatigue
❑ Exhaustion	❑ Weight Change	❑ Night Sweats
❑ Fainting	❑ Chest Pain	❑ Palpitations
❑ Lightheadedness	❑ Involuntary Urination	❑ Frequent Urination
❑ Pain on Urination	❑ Blood in Urine	❑ Muscle Cramp/Pain
❑ Muscle Weakness	❑ Joint Pain	❑ Neck Pain
❑ Back Pain	❑ Arm Pain	❑ Leg Pain
❑ Seizures	❑ Head Injury	❑ Headaches
❑ Numbness	❑ Unsteadiness	❑ Dizziness/Vertigo
❑ Difficulty Speaking	❑ Weakness of Arms/Legs	❑ Blurred Vision
❑ Double Vision	❑ Loss of Vision	❑ Eye Pain
❑ Cough	❑ Shortness of Breath	❑ Swelling
❑ Unusual Bleeding	❑ Easy Bruising	❑ Nose Bleed
❑ Excessive Sweating	❑ Excessive Thirst	❑ Excessive Sleep
❑ Sexual Dysfunction	❑ Loss of Sexual Desire	❑ Loss of Hearing
❑ Ringing in Ears	❑ Change in Taste or Smell	❑ Difficulty Swallowing
❑ Nausea	❑ Vomiting	❑ Diarrhea
❑ Constipation	❑ Blood in Stools	❑ Rash
❑ Breast Discharge	❑ Unhealed Wound	❑ Change in Mental Function
❑ Change in Memory	❑ Confusion	❑ Anxiety
❑ Depression	❑ Difficulty Sleeping	❑ Other: ____________________

HIPAA Right of Access Form for Family Member/Friend
HIPAA Authority for Right of Access: 45 C.F.R. 164.524

I, ________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to (if none, please write none):

Name	Relationship	Phone Number

Health information to be disclosed upon the request of the person named above (check either A or B):

_____ **A.** Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions).

OR

_____ **B.** Disclose my health record, as above, **BUT** do not disclose the following:

(check as appropriate):
_____ Mental Health Records
_____ Communicable Diseases (including HIV and Aids)
_____ Alcohol/Drug Abuse Treatment
_____ Other (please specify): ____

This authorization shall be effective until (check one):

_____ All past, present, and future Periods

OR

_____ until: (Date) ______________, unless revoked before then in writing

(**Note:** You may revoke this authorization in writing at any time by notifying your health care providers)

Printed name of the patient authorizing: __________________________ Relationship to Patient: _____________
Signature of patient or guardian: ____________________________________ Date: ____________________

Office Use Only:
Printed Name of Employee Receiving: ____________________________________
Signature: ___________________________________ Date: ___________________

ORLANDO
ADVANCED PRIMARY CARE

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, n or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identij appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatmen signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encour you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Patient Consent for Medical Photography

Patient name: ______________________________ Date: ____________

☐ check here if minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

____

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

______________________ (Signature) ______________________ (Witness)

2) I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publication:

______________________ (Signature) ______________________ (Witness)

3) I agree to use of my image for medical records **ONLY**:

______________________ (Signature) ______________________ (Witness)

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above.

______________________ (Signature of patient) ______________________ (Witness)

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right a restriction on uses and disclosures of their protected health information (PHI). The ir is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone ____________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐

☐☐Work Telephone ____________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ ☐May fax copies of any reports I request to number ☐
____
____

Other: ____________________

I ____________________, do hereby authorize OAPC to Release any and all information concerning my medical condition, including test results, medication changes, diagnostic appointments, etc. to the following people:

Name	Relationship
____________________	____________________
____________________	____________________
____________________	____________________

Also, in the event I am unable to make my own medical decisions, I hereby authorize the following to make those decisions on my behalf:

Name	Relationship
____________________	____________________
____________________	____________________
____________________	____________________

____________________ Patient Signature

____________________ Date

____________________ Print Name

____________________ Birth Date

ORLANDO ADVANCED PRIMARY CARE

SHWETANSHU SHUKLA,MD/SANDEEP PANDYA,MD

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ______________________, have received a copy of **OAPC'S** Notice of Privacy Practices.
Patient Name

____
Signature of Patient

____
Date