

Valley Health Care

Patient History form for Men

Please answer these questions to the best of your ability. The information provided will help Dr. Anne take better care of you. This information is confidential and will not be released without your consent.

Name: _____ Birth Date: _____

Date: _____ Social Security Number: _____

Why are you here today?

Circle any of the following you have had and enter the approximate **date or age**:

High Blood Pressure _____ Heart Disease _____

Diabetes _____ High Cholesterol/Triglycerides _____

Lung Disease _____ Kidney Disease _____

Jaundice _____ Pneumonia/Asthma _____

Tuberculosis _____ Chicken pox infection or vaccine _____

Thyroid disease _____ Orthopedic problems _____

Depression _____ Anxiety _____

Glaucoma _____ Macular Degeneration _____

Other Medical Problems:

Are you **allergic** to any medications? Please list them along with the **reaction** you had:

List any Serious Injuries

Hospitalizations/Operations (Please give **year or approx. date**)

Indicate whether you have had any of the following procedures and the **approximate year**:

Cardiac Stress Test _____ Colonoscopy _____

Immunizations are an important part of your total health picture.

What have you had & when?

Tetanus _____ Pneumovax (or the "Pneumonia vaccine") _____ Flu _____

Hepatitis B (this is a 3 shot series) _____ MMR booster _____ Shingles _____

FAMILY HISTORY

[Remember this is about your family **not** you]

	Year of Birth	Medical Conditions	Age at Death (if deceased)	Cause of Death
<u>Mother</u>	_____	_____	_____	_____
<u>Father</u>	_____	_____	_____	_____
<u>Brother</u>	_____	_____	_____	_____
<u>Brother</u>	_____	_____	_____	_____
<u>Sister</u>	_____	_____	_____	_____
<u>Sister</u>	_____	_____	_____	_____

Indicate which of the following conditions your blood kin have had (place **relationship in blank**):

High Blood Pressure _____	Heart Attack _____	Stroke _____
High Cholesterol _____	Diabetes _____	Stomach ulcer _____
Depression _____	Nervous Breakdown _____	Alcoholism _____
Other Addictions _____	Arthritis _____	Asthma _____
Osteoporosis _____	Migraines _____	Tuberculosis _____
Colitis _____	Kidney disease _____	Liver Disease _____
Leukemia _____	Sickle Cell Anemia _____	Bleeding Tendency _____
Breast cancer _____	Colon Cancer _____	Prostate Cancer _____
Testicular cancer _____		

Additional Comments:

TOBACCO USE:

YES NO Do you use any type of tobacco products? If not, skip to alcohol section.

YES NO Do you dip or chew?

YES NO Have you ever smoked?

YES NO Do you smoke now? If "YES", how many packs per day? _____

Age you **started** smoking? _____ Are you interested in quitting? _____

If you've stopped, age you stopped _____. **Congratulations for being a "quitter"!** 😊

ALCOHOL USE:

YES NO Do you **ever** have alcoholic beverages? If "no" go to next section.

YES NO Do you have **more than 3** drinks per week?

YES NO Have you ever **cut back** on your alcohol consumption?

TELL US ABOUT YOURSELF!

Education: [last high school grade completed, GED, High School, College, Post graduate]

Occupation:

Marital Status:

Single, never married -----

Divorced (year) -----

Married (year) -----

Widowed (year) -----

List all the people who live at home with you (list name, relationship to you & year of birth):

Hobbies: -----

SAFETY:

- | | | |
|-----|----|---|
| YES | NO | Do you wear seat belts? |
| YES | NO | Are there handguns in your home? |
| YES | NO | Do you keep handguns locked and away from kids? |

EXERCISE:

YES NO Do you exercise?

YES NO Do you exercise at least 30 minutes three times a week?

Place a CHECK by any of the listed symptoms that **currently** apply to **you**:

Skin, Hair & Nails

- ____ Color Changes
- ____ Itching
- ____ Moles
- ____ Infections
- ____ Rash
- ____ Hair/Nail Change

Constitutional

- ____ Weakness
- ____ Fatigue
- ____ Fever
- ____ Chills
- ____ Night Sweats
- ____ Change in Appetite

Blood

- ____ Anemia
- ____ Enlarged glands
- ____ Blood Transfusion
- ____ Year of transfusion
- ____ Easy Bruising
- ____ Excessive bleeding

Eyes

- ____ Vision Changes
- ____ Pain/Infection
- ____ Wear Glasses/Contacts
- ____ Date of last eye exam

Ears

- ____ Pain
- ____ Discharge
- ____ Hearing Loss
- ____ History of infections

Teeth

- ____ Problems
- ____ Regular Dental Care
- ____ Floss daily 😊
- ____ Brush twice a day

Endocrine

- ____ Goiter
- ____ Heat Intolerance
- ____ Cold Intolerance
- ____ Palpitations
- ____ Change in Voice
- ____ Frequent Urination
- ____ Excessive Thirst
- ____ Overeating
- ____ Weight Gain
- ____ Weight Loss
- ____ Flushing
- ____ Infertility

Musculoskeletal

- ____ Joint Pain
- ____ Joint Heat
- ____ Joint Redness
- ____ Joint Stiffness
- ____ Joint Injury
- ____ Bone difficulty
- ____ Muscle Spasm
- ____ Muscle Tenderness
- ____ Morning Stiffness
- ____ Height Loss
- ____ Osteoporosis
- ____ Spine problems

Respiratory

- ____ Cough
- ____ Sputum
- ____ Shortness of Breath
- ____ Wheezing
- ____ Pleurisy
- ____ Asthma
- ____ Spitting up Blood
- ____ Seasonal Allergy
- ____ **Date**-last Chest X-ray
- ____ History of inhaler use?
- ____ **Year** of your most recent TB skin test.

Place a CHECK by any of the listed symptoms that **currently** apply to you:

Gastrointestinal

- ____ Appetite Change
- ____ Nausea
- ____ Vomiting
- ____ Difficulty Swallowing
- ____ Indigestion
- ____ Excessive Gas
- ____ Vomiting Blood
- ____ Abdominal Pain
- ____ Jaundice
- ____ Use of Antacids
- ____ Diarrhea
- ____ Constipation
- ____ Blood in Stool/Toilet Tissue
- ____ Hemorrhoids
- ____ Hernia
- ____ Use of Laxatives
- ____ Frequent Bowel Movements
- ____ Change in Bowel Habits

Nervous System

- ____ Convulsions/Seizures
- ____ Faintness
- ____ Incontinence
- ____ Stroke
- ____ Speech Difficulty
- ____ Dizziness
- ____ Tremor
- ____ Trouble Walking
- ____ Change in Sensation
- ____ Transient Blind Spells
- ____ Loss of Coordination
- ____ Numbness
- ____ Tingling
- ____ Trouble rising from chair
- ____ Migraines
- ____ Other types of headaches
- ____ Carpal Tunnel Syndrome
- ____ Tennis Elbow

Depression

- ____ Anger
- ____ Nervousness
- ____ Anxiety
- ____ Nightmares
- ____ Insomnia
- ____ Feelings of guilt
- ____ Trouble concentrating

Urinary Tract

- ____ trouble starting stream
- ____ frequent infections
- ____ Small Urinary Stream
- ____ Can't Hold Urine
- ____ Backache
- ____ Pain w/Urination
- ____ Kidney Stones
- ____ Blood in Urine
- ____ Frequency

Cardiovascular

- ____ Chest Pains
- ____ Shortness of breath lying down?
- ____ How many pillows for sleep?
- ____ Palpitations
- ____ High Blood Pressure
- ____ History of Rheumatic Fever
- ____ Calves hurt when walking
- ____ Fingers or toes hurt when cold
- ____ Shortness of breath on exertion?
- ____ Shortness of breath at night?
- ____ Swelling of Feet
- ____ Fainting spells
- ____ Heart Murmur
- ____ Varicose Veins
- ____ Mitral Valve Prolapse
- ____ Was MVP confirmed by an echocardiogram?
This is an ultrasound of the heart.
- ____ Antibiotics must be used prior to dental work.

MEN'S ISSUES:

INFECTIONS:

It's OK if you would rather talk about these sensitive issues and not answer these questions in writing.

Have you ever had a sexually transmitted disease? YES NO

Which one? Chlamydia YES NO Human Papilloma Virus YES NO

Herpes YES NO Genital Warts YES NO

Gonorrhea YES NO Any other infections? _____

TESTICLES:

YES NO Monthly self exam

YES NO Pain in testicles?

YES NO Testicular masses?

MISCELLANEOUS:

YES NO PSA TEST? When? _____

YES NO Erection problems?

YES NO Sexuality issues/concerns?

YES NO Prostate enlargement?

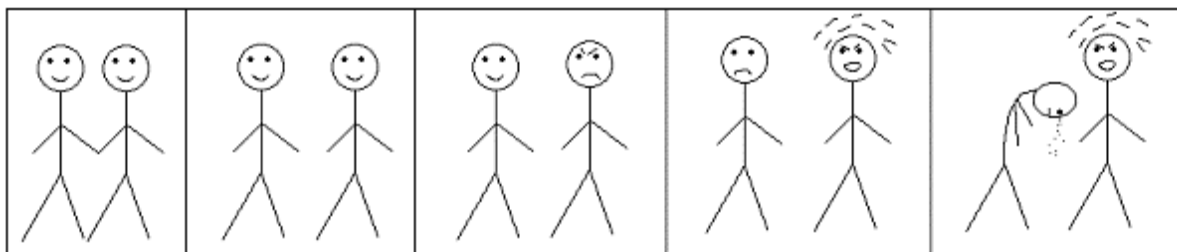
YES NO Prostate infections

The Relationship Chart:

DURING THE PAST 4 WEEKS, HOW OFTEN HAVE PROBLEMS IN YOUR HOUSEHOLD LED TO:
INSULTING OR SWEARING? YELLING? THREATENING? HITTING OR PUSHING?

None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
------------------	----------------------	------------------	------------------	-----------------

PLEASE CIRCLE THE RELATIONSHIP THAT IS MOST LIKE YOUR HOUSEHOLD



Congratulations! You are at the end of this form. Your answers will be very useful to us in advising you about your healthcare. I view our patient-physician relationship as a team concept in which my main role is to educate, inform, present options and recommendations. I feel privileged to participate in your healthcare.

Dr. Anne

VALLEY HEALTH CARE

PATIENT REGISTRATION					
First Name		Middle Initial		Last Name	
Birthdate	Sex	Marital Status		Social Security #	
Street Address			City	State	Zip
Mailing Address (if different)				Home Phone ()	
Employer	Employer Address			Employer Phone ()	
Emergency Contact (someone not living with you)				Emergency Phone ()	
WHO IS RESPONSIBLE FOR THE PATIENT'S BILL?					
First Name		Middle Initial		Last Name	
Birthdate	Sex	Marital Status		Social Security #	
Mailing Address			City	State	Zip
PRIMARY INSURANCE INFORMATION					
Name of Insurance Company			Birthdate	Name of Insured Member	
Employer	Employer Address			Employer Phone ()	
Group Number		Policy Number		Relationship to Patient	
SECONDARY INSURANCE INFORMATION					
Name of Insurance Company			Birthdate	Name of Insured Member	
Employer	Employer Address			Employer Phone ()	
Group Number		Policy Number		Relationship to Patient	

E-Mail Address: _____

ANNE W. WHITE MD, PC.
Authorization for Release of Medical Information

Patient Name	Birth Date	Social Security No
Address	Home Phone:	
	Other Phone:	
<p>I hereby authorize _____ <i>Name of Individual/organization being asked to release information</i></p> <p>to release medical records of the patient to:</p> <p>Dr. Anne White Phone (706) 295-5150 909 N 5th Avenue NE Fax (706) 295-4865 Rome, GA 30165-2706</p> <p>Purpose of release of records:</p> <p><input type="checkbox"/> At the request of the individual signing this authorization</p> <p><input type="checkbox"/> Other reasons: _____</p> <p>For what treatment dates:</p> <p><input type="checkbox"/> All treatment dates</p> <p><input type="checkbox"/> Treatment dates of _____ to _____</p>		
Requested Access Types	Specific description of information to be disclosed:	
<input type="checkbox"/> Copying of Records	<input type="checkbox"/> All records for the given time period	
<input type="checkbox"/> Examine Records	<input type="checkbox"/> Other: _____	
<p>I understand that any information disclosed pursuant to this authorization is subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by contacting the appropriate person(s) at Dr. Anne White's office, unless action has already been taken in reliance of this authorization. Aside from this, I understand that upon expiration of this authorization, no further disclosures of information will be made. I further understand that the records to be released may contain or consist of information related to the following: contagious diseases (HIV/AIDS, hepatitis, etc.); psychiatric treatment or drug/alcohol abuse.</p>		
Date	Signature of Patient/Guardian	Relationship to Patient
<p>This authorization will expire 90 days from the date specified above or the date on which the requested release has been completed, whichever comes first.</p>		
Official Office Use Only		
Date	Signature:	Date of Review Facility Representative Present for Review

ANNE WHITE M.D. PC

MEDICATION REFILL POLICY

The following is the Medication Refill Policy for the office of Dr. Anne White. These policies are in place to provide you with timely medication refills and to ensure your protection as a patient under our care.

- 1. It is the patient's responsibility to address all medication issues/refills at the time of your appointment.**
- 2. Please notify our office two (2) days in advance of when you need a medication refilled.** It is the patient's responsibility to notify our office in a timely manner of medication refills to ensure adequate time to process your request. Due to the large volume of requests, **it is not possible to refill your request on the same day it is made.**
3. Please check with your pharmacy **24 hours** after making your request before calling the office to check the status of your refill request.
4. You will be notified by phone if your refill is not approved; otherwise, your prescription will be phoned in to the designated pharmacy.
5. Please notify us by 11:00 a.m. on Thursdays for any medication refills needed prior to the weekend. **NO NARCOTICS WILL BE REFILLED ON WEEKENDS OR AFTER HOURS.**
6. Early medication refills will **NOT** be permitted. Your medication should be taken exactly as directed by your physician.
7. **Requests for written prescriptions must be made at least 3 days in advance.** You may personally pick up written prescriptions or the office can fax them to your designated pharmacy. We are sorry but we cannot mail written prescriptions to the patients.
- 8. Prescriptions lost for any reason will be re-written for a small fee of \$5 payable at your next office visit.**
9. All patients on narcotics or any controlled substance are expected to agree to sign our controlled substance contract. A copy of this is in the patient manual.

I have read the above policies and I understand them.

Patient/Guardian Signature

Date

Valley Health Care

Patient Authorization for Use and Disclosure of Protected Health Information

This authorization permits **Valley Health Care** to use and/or disclose certain protected health information (**PHI**). By signing I authorize **Valley Health Care** to disclose the following individually identifiable health information about me to: _____

Please circle one:

Medical

Financial

Both Medical and Financial

This purpose is provided so that I can make an informed decision whether to allow release of the information. I do not have to sign this authorization in order to receive treatment from **Valley Health Care**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal **HIPAA Privacy Rule**. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Valley Health Care
909 North Fifth Ave. N.E.
Rome, GA 30165-2706

Signed by: _____

Signature of Patient

_____ Date

_____ Print Patient's Name

Many of our new programs, such as patient portal and our Electronic Health Record Program now require race and language in order to perform certain functions. Please circle the race and language that describes you:

Race:

African-American Asian Caucasian Hispanic (Caucasian) Hispanic (non-Caucasian)
Native American Other Pacific Islander Do Not Wish to Disclose

Language:

English Spanish American Sign Language Japanese
Vietnamese French other: _____ Do Not Wish to Disclose

Emergency Contact: _____ **Relationship** _____

Emergency Contact Phone Numbers: _____

Patient will be provided with a signed copy of this authorization form upon request.

Valley Health Care

1. **CONSENT FOR TREATMENT:** I hereby authorize VHC including Dr. Anne White or any other healthcare professionals and assistants to **provide and render treatment** to the below named patient as necessary including, but not limited to the following: physical examination, laboratory testing, x-rays and other imaging procedures, diagnostic testing, medication, physiotherapy, suturing and office surgical procedures.
2. I authorize the **release by VHC of all of my medical records and information** necessary to process my medical insurance claims which may include contacting my employer for coverage, eligibility, and benefits information.
3. I authorize and request **payment of medical benefits directly** to VHC and to Dr. Anne White.
4. I authorize VHC and Dr. Anne White to release my medical records and related information to any physician, hospital, or other medical treatment facility to which I **may be referred for medical care and treatment**.
5. If the payment of any medical care is to be made by anyone beside myself, or if I am a participant in a managed care organization, **I authorize the release** by VHC and Dr. Anne White of my medical files and related financial billing information to such third party[ies], including records, files and information related to psychiatric and psychological care; drug and alcohol abuse; child or adult abuse or neglect; and confidential HIV/AIDS information, in order that VHC or Dr. Anne White may comply with the disclosure requirement of such plan[s], or for any reason requiring release of my medical files and records as contained in the Agreement between my plan and VHC, or Dr. Anne White.
6. I authorize VHC and Dr. Anne White to **release my medical records and related billing information** to any physician or physician's agent who contracts with PAWH for the purpose of examining and/or verifying the billing, coding, and collection procedures and practices of VHC.
7. I am **personally responsible** for the payment to VHC and Dr. Anne White for all charges that occur as a result of my medical treatment, unless I am a participant in a managed care organization or being treated for a worker's compensation injury, which may limit my liability.
8. VHC and Dr. Anne White participate with the **Medicaid program** on an individual basis. She will provide the full range of Medicaid covered services normally provided by such physician. Medicaid services may require prior authorization. If I am a Medicaid patient, I authorize the holder of medical records and related billing information about me to release such records and information needed for any of my Medicaid related claims to the governmental departments or agencies administering the Medicaid program.
9. If I am a **worker's compensation patient**, I authorize VHC and Dr. Anne White to communicate, both orally and in writing, with my employer to discuss my medical condition and treatment resulting from my worker's compensation injury.
10. If I am a **Medicare** enrollee, I authorize the holder of medical or other information about me to release to the Social Security Administration and Medicare administrator or its intermediaries or carriers any information needed for any of my Medicare related claims. I request payment of medical insurance benefits either to myself or to the party who accepts assignment; I understand that regulations pertaining to Medicare assignment of benefits apply.
11. I agree that this authorization will cover all medical services rendered until such authorization is **revoked in writing by me**. A photocopy of this form may be used in lieu of the original.
12. I authorize **any and all pharmacies and pharmacists to release to VHC and Dr. Anne White** requesting it, all information concerning my pharmaceutical records.
13. Due to Valley Health Care's strict policy of releasing information only to the patient or legal guardian, we need your authorization if we are to discuss your appointments or financial information with anyone else. I authorize Valley Health Care to furnish my appointment and financial information to _____, my personal representative, who may be contacted at _____ [contact #].

* An additional HIPPA form is required to release Private Health Information to any others except the patient. *

14. In the event that PAWH is unable to reach me, **a staff member may leave a message on my answering machine** ___ YES ___ NO.
15. I consent to **the review of my medical record for the purpose of clinical research**. I understand that any information collected is confidential and that my identity will be protected. ___ YES ___ NO.

signed [patient or authorized representative]

Date

print [patient name]