CORNERSTONE

FAMILY WELLNESS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS &
COMPREHENSIVE HEALTH HISTORY FORMS

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records of Dr.

Address:

Telephone number ( ) ___ - _____ Fax number ( ) ___ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to _____

all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse*:* O Yes O No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III

test results or treatment: O Yes O No

Genetic Testing O Yes O No

Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release _____

(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name:_____ D.O.B._____

Please Print

Signature: _____ Date_____

Relationship to Patient: _____

Records Requested by:

Doctor's Name: _____

Signature:_____

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date: _____

First Name: _____Middle: _____ Last:_____

Address _____ City _____ State _____ Zip _____

Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female __ Male __

City or town & country, if not US

Referred by: _____

Name, address, & phone number of referring physician: _____

_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____

Relationship Name Phone

Occupation _____ Hours per week _____

Nature of Business _____

Genetic Background: Please check appropriate box(es)

☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other

INSURANCE INFORMATION

Please note: The office visit is not billed through insurance and is a self-pay service. If additional services such as labs or pap smears are needed, those may be billed to your insurance plan if requested.

Primary Insurance

Insurance Company: _____ Policy # _____ Group # _____

Subscribers Name: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____ Policy # _____ Group # _____

Subscribers Name: _____ DOB: _____

Relationship to Patient: _____

PHARMACY

Please list pharmacy name, phone number and address.

_____

_____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced a reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN/ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		

Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinustis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Back injury		
Broken bones or fractures (describe)		
Heads injury		
Neck injury		
Other (describe)		

Please list any surgeries or major hospitalizations you have had, and when they happened.

_____

_____

_____

MEDICATIONS

List all medications. Include all over the counter non-prescription drugs/supplements.

Medication Name	Date started	Date stopped	Dosage

ALLERGIES

Please list any allergies to medications or food.

ALLERGY	REACTION

FEMALE MEDICAL HISTORY ALLERGIES

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide the number of pregnancies and/or occurrences of conditions.

☐ Pregnancies _____	☐ Caesarean _____	☐ Vaginal Deliveries ____
☐ Miscarriage _____	☐ Abortion _____	☐ Living Children _____
☐ Postpartum Depression _____	☐ Toxemia _____	☐ Gestational Diabetes _____

DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal: Abnormal

Last Mammogram_____/_____/_____ Breast biopsy?

Date:_____/_____/_____

PEDIATRIC SECTION

(For children only)

How frequently has your child taken antibiotics? _____

Gestational age at birth: ☐ Full-term ☐ Premature

Please specify weeks if premature: _____

Were there any complications at birth? _____

Infant feeding history: ☐ Breastfed ☐ Bottle-fed ☐ Both

Age of first period (if applicable): _____

Parent/Guardian Name(s): _____

Who does the child live with? _____

Please list all parties that can accompany child to an appointment if parents are not present.

NAME	RELATIONSHIP

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge.

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									

Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									

Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___

Cigar ___ Pipe ___ Patch/Gum ___ How much?

Number of years? If not a current user, year quit

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:_____

_____

_____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____ Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____ If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____

_____

_____

EXERCISE HISTORY

How much exercise do you get in a typical week?

_____

ADDITIONAL QUESTIONS

Have you recently had a bone density test? (If not applicable, please write N/A.)

_____

Have you ever had a colonoscopy? If so, when was your last? (If not applicable, please write N/A.)

_____

Have you seen any specialists recently? If yes, please list them.

_____

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent or guardian name (if applicable): _____

Relationship to patient (if applicable): _____

Signature of patient, parent or guardian: _____

Today's Date: _____