PAID: _____

ROOM: _____

J. M. Adelberg, MD, FAEP
General Practice

☐ New Patient ☐ Returning Patient

DEMOGRAPHICS and H&P

PATIENT INFORMATION Date: _____

Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Phone: _____ Email Address: _____

Address: _____

Ethnicity: _____ Social Security #: _____

Employer: _____ Occupation: _____

Is the Patient at Minor: **Y or N** If Yes, Relationship to Patient: _____

Parent/Guardian Name: _____ Signature: _____

HIPAA Authorization for Release of Information to Family and/or Friend

J.M. Adelberg General Practice is authorized to release protected health information about the above-named patient as follows:

1. ☐ Leave information on voicemail at: Home ___ Work ___ Mobile ___ Phone: _____
2. ☐ Give information to spouse: Name of Spouse: _____
3. ☐ Give information to: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____ Phone: _____

PREFERRED PHARMACY

Name: _____ Address: _____ Phone: _____

LIST OF CURRENT MEDICATIONS

Medication Name	Dose/MG	How often

ALLERGIES:

_____ Type of reaction: _____

_____ Type of reaction: _____

_____ Type of reaction: _____

FOR OFFICE USE

Vitals:

B/P: _____ /_____ Temp.: _____ O2: _____ Pulse: _____ Weight: _____ Height: _____ Resp: _____

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REVIEW OF SYSTEMS	YES	NO
GENERAL:		
Do you usually feel persistently tired or worn out?	_____	_____
Have you recently been drinking more water or fluids?	_____	_____
Has there been any unusual weight gain or loss recently?	_____	_____
CARDIOVASCULAR:		
Do you have pain, tightness, or pressure in the front or back of your chest?	_____	_____
Does your heart ever beat fast or irregularly?	_____	_____
Do you have any swelling of your feet or ankles?	_____	_____
Do you have cramps in the calf muscle when you walk?	_____	_____
Do your fingers or toes ever get cold, become numb, or get very white or bluish?	_____	_____
Have you ever been told you have a heart murmur?	_____	_____
CENTRAL NERVOUS SYSTEM:		
Do you have frequent or severe headaches?	_____	_____
Do you often have spells of dizziness, faintness, or lightheadedness?	_____	_____
Have you recently fainted, blacked out, or lost consciousness?	_____	_____
EYES:		
Have you had any pain in your eyes, blurry vision or had a change in your vision?	_____	_____
Have you had cataracts or implants?	_____	_____
When did you last see an eye doctor? _____ Was the exam normal?	_____	_____
ENT:		
Do you have any trouble hearing; have ringing, or buzzing in your ears?	_____	_____
Do you have persistent hoarseness?	_____	_____
Do you have sinus trouble?	_____	_____
Do you use a hearing aid?	_____	_____
When did you last visit a dentist? _____		
GASTROLINTESTINAL:		
Have you recently noted any trouble swallowing?	_____	_____
Do you have a lot of indigestion or heartburn?	_____	_____
Have you ever vomited blood?	_____	_____
Are you bothered by constipation or frequent loose stools or diarrhea?	_____	_____
Have you recently had any change in the frequency of bowel movements?	_____	_____
Do you have blood in your stool or black, tarry stool?	_____	_____
SKIN:		
Do you have any rashes or itching?	_____	_____
Do you have any growths or lumps on your skin?	_____	_____
Do you have any sores or wounds that do not heal?	_____	_____
Do you have any change in the color or size of warts or moles?	_____	_____
Do you have any change in your nails?	_____	_____
GENITOURINARY:		
Do you have burning or pain when you urinate?	_____	_____
Do you have to pass water frequently?	_____	_____
Do you have to get up at night to urinate? How often? _____ times per night.	_____	_____
Do you have trouble starting or stopping your urine?	_____	_____
Do you have trouble with losing urine when you cough or sneeze?	_____	_____
Have you ever passed blood in your urine?	_____	_____
Have you ever had an operation to prevent pregnancy? **(Such as: Vasectomy or Sterilization or Tubal Ligation)**	_____	_____
MUSCULOSKELETAL:		
Do you have a problem with back pain?	_____	_____
Do you have joint pain or stiffness (Arthritis)?	_____	_____
Do you have numbness or tingling in your arms or legs?	_____	_____

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	YES	NO
RESPIRATORY:		
Do you have a constant or bothersome cough?	_____	_____
Do you cough up blood?	_____	_____
Do you have difficulty breathing at rest, or when exercising?	_____	_____
Do you have a history of a positive reaction to a tuberculosis (TB) skin test?	_____	_____
PSYCHIATRIC:		
Do you have feelings of depression?	_____	_____
Do you have feelings of anxiety, nervousness, or tenseness?	_____	_____
Do you have problems with your temper?	_____	_____
Do you have problems with memory?	_____	_____
Do you have trouble sleeping?	_____	_____
ENDOCRINE:		
Do you have thyroid trouble?	_____	_____
Do you have heat or cold intolerance?	_____	_____
Do you have excessive sweating, thirst, or hunger?	_____	_____
HERMATOLOGIC/ANEMIA: **Are you anemic?**	_____	_____
Do you bruise or bleed easily?	_____	_____
Do you notice any lumps in your neck, armpits, or groin?	_____	_____
MEN ONLY:		
Do you have prostate gland trouble?	_____	_____
Have you had herpes?	_____	_____
Do you have any discharge or drip from your penis?	_____	_____
Do you know how to examine your testicles? If so, do you do this at least monthly	_____	_____
WOMEN ONLY:		
Date of last period: _____ Was your last period normal?	_____	_____
Have you passed menopause or change? If so, what year? _____	_____	_____
Date of last pap smear: _____ Was your last pap smear normal?	_____	_____
Date of last mammogram: _____ Was your last mammogram normal?	_____	_____
Did you have any pregnancies? **How many: ___ Premature ___ Full Term ____ Abortions ___ Miscarriages ___**	_____	_____
Do you know how to examine your breasts? How often do you examine your breasts? _____	_____	_____
Do you have any lumps in your breasts or have any discharge from your nipples?	_____	_____
Do you have any vaginal drainage?	_____	_____
Do you have any prolapse ("falling out") of the vagina or uterus?	_____	_____
Have you had herpes?	_____	_____

OPERATIONS AND SURGERIES:

- Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

- Have you ever had any operations/surgeries? ☐ Yes ☐ No

If yes, please explain: _____

- Have you ever had any infectious deceases? ☐ Yes ☐ No

If yes, please explain: _____

- Have you ever had any broken bones (fracture) or dislocations? ☐ Yes ☐ No

If yes, please explain: _____

- Have you ever been knocked unconscious? ☐ Yes ☐ No

If yes, for how long? _____

FAMILY HISTORY:

Father: ☐ Living ☐ Deceased Any Illness? _____
Mother: ☐ Living ☐ Deceased Any Illness? _____
Sibling: ☐ Living ☐ Deceased Any Illness? _____

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TOBACCO USE ASSESSMENT AND CESSATION INTERVENTION:	**YES**	**NO**
Do you currently smoke or chew tobacco or have you in the past 2 years?	_____	_____
If Yes: Do you have any desire to quit?	_____	_____
Do you wish assistance on quitting?	_____	_____

AUDIT-C (Alcohol Use Disorders Identification Test) *(M>=4, F>=3)*

How often did you have a drink containing alcohol in the past year?
- (0) Never
- (1) Monthly or Less
- (2) 2-4 times a month
- (3) 2-3 times a week
- (4) 4 or more

How many drinks containing alcohol do you have on a typical day when drinking?
- (0) 1 or 2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7, 8, or 9
- (4) 10 or more

How often do you have six or more drinks on one occasion?
- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems:

(use " ✓ " to indicate your answer)

LIST	NOT AT ALL	SEVERAL DAYS	More Than ½ the Days	Nearly Every Day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Felling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself, feeling that you are a failure or feel you have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things such as: reading the newspaper or watching televisi	0	1	2	3
8. Moving or speaking so slowly that other people could have Noticed. The opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

MINIMAL 1-4 MODERATE-SEVERE 15-19 MILD 5-9 SEVERE 20-27 MODERATE 10-14 ADD COLUMNS: _____ TOTAL SCORE: _____

HIPAA Privacy Notice & Attestation for true and correct information provided today:

Privacy Rights: I hereby acknowledge that a written Notice of Privacy Practice is available upon request and posted for me to review. The Privacy Practice provides a complete description of how my health information may be used or disclosed. I understand that I have the right to review the practice notice prior to signing this consent. I understand that J.M. Adelberg, MD, FAEP, General Practice, reserves the right to change their notice and information practices. I may obtain a copy of the revision by written request. I understand that I have the right to restrict how J.M. Adelberg, MD, FAEP, General Practice, uses or discloses my protected health information to carry out treatment, receive payment and conduct healthcare operations. J.M. Adelberg, MD, FAEP, General Practice, is not required to agree to the restriction. J.M. Adelberg, MD, FAEP, General Practice, is bound by restrictions to which it agrees. **To the best of my ability, all of the information I have entered on the patient intake package today is honest and correct.**

_____ _____ _____

Patient Name **Patient Signature** **Date**

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Consent To Treatment (Minor) *If Applicable* I hereby request and authorize J.M. Adelberg, MD., FAEP, General Practice, to treat: Patient Name: _____. Guardian's Name: _____ Relation to Patient: _____ This authorization also extends to all other providers and office staff members. As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse / former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____

Guardian Signature Date

PROVIDER NOTES: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication(s) Required Today:

Follow up: **2 weeks** **30 days** **60 days** **90 days** **6 months** **PRN**