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SAINT AGNES HEALTHCARE
ASCENSION

Addressograph

New-Patient Medical-History Form

Welcome!

Name: _____ **DOB and age:** _____ **Date:** _____

How are you feeling today? _____ **Reason for referral:** _____

Referring doctor(s): _____ **Primary doctor(s):** _____

Symptoms (circle all that apply): Pain Nausea Bulge or mass Diarrhea Bleeding Itching None
Other: _____ Symptoms started on: _____
Character of pain: Dull Sharp Tearing Burning Crampy None Other: _____
Symptoms are: Mild Moderate Severe; Pain score (0-10): At worst _____ and now _____
Pain: Is constant Comes and goes Lasts how long: _____
What makes symptoms better: _____; What makes them worse: _____
Other information about your symptoms: _____
_____

Previous CT, MRI, US, or other tests: _____
_____

Please list all **Medical Problems**:

_____
_____
_____
_____
_____

Please list all **Operations** and dates as best as you can recall:

_____
_____
_____
_____
_____

Please list all **Medications** and doses if you know them:

_____
_____
_____
_____
_____

Allergies: _____

Name: _____ **DOB and age:** _____ **Date:**_____

Please list any **Family Medical History:**

_____

_____

Social History (check, fill in the blanks, or circle):

I am/have: Married Single Divorced Widowed Partner Significant Other/Boyfriend/Girlfriend
I live with: _____ Number of children: ____ and ages: _____

I am currently working as a _____ at _____
I used to work as a _____ but _____

[] I am currently smoking _____ packs per day and have been smoking for _____ years.
[] I smoked _____ packs per day for _____ years but quit in _____.
[] I have never smoked.

[] I currently have _____ alcoholic drinks per day and have been drinking for _____ years.
[] I used to drink _____ drinks per day for _____ years but now _____.
[] I have never drunk alcohol.

[] Any recent recreational drug use: _____; or [] None.

Please carefully read this **Review of Symptoms:**

Check "None" or Circle any that apply below:		
GENERAL	[] None	Weight loss or gain, fatigue, fever, night sweats, or change in appetite. How many blocks or flights of stairs you can climb: _____.
INTEGUMENTARY	[] None	Rashes, itching, tattoos, or color change.
HEENT	[] None	Headaches, vision changes, or enlarged nodes or glands.
RESPIRATORY	[] None	Cough, wheezing, shortness of breath, or asthma.
CARDIAC	[] None	Chest pain, heart flutter, or heart murmurs.
GASTROINTESTINAL	[] None	Nausea, vomiting, change in bowel habits, bleeding, constipation, diarrhea, abdominal pain, bloating, hepatitis, light-colored or floating stool, or reflux.
ENDOSCOPY	[] None	Date of last colonoscopy: _____. Last upper endoscopy: _____.
GENITOURINARY	[] None	Painful, difficult, frequent urination, incontinence, or dark urine.
RENAL	[] None	Kidney stones or other problems.
ENDOCRINE	[] None	Thyroid problems or diabetes.
MUSCULOSKELETAL	[] None	Weakness or joint pains.
NEUROLOGICAL	[] None	Fainting, seizures, stroke, loss of vision, or trouble speaking.
HEMATOLOGIC	[] None	Easy bruising or bleeding, anemia, or blood transfusion.
VASCULAR	[] None	Leg pain when walking, blood clots, stroke.
INFECTIOUS	[] None	Recent infections. I take antibiotics before dental procedures.
BREAST	[] None	Pain, history of lumps, or nipple discharge. Date of last mammogram on _____, or [] None.
GYNECOLOGIC	[] None	Vaginal bleeding or discharge.

Reviewed by physician: _____

MARYLAND SURGEONS

Date_____

Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex _____ Marital Status _____

Home Phone # _____ Work Phone # _____ Cell# _____

Employer _____ Preferred language:_____Race: _____

Email address: _____

Pharmacy: _____City: _____Pharmacy Phone #:_____

Person to Notify in an Emergency _____

Relationship _____ Phone Number _____

Primary Care Physician _____ Referring Physician _____

Insurance Information:

Primary Insurance _____

Are you the policyholder? _____Yes ____No (*this information is NOT on the card*)
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Secondary Insurance _____

Are you the policyholder? _____Yes ____No
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Other Health Care Providers

GYN Name_____Phone _____Fax_____

Gastroenterologist _____Phone_____Fax_____

Oncologist _____Phone_____Fax_____

MARYLAND SURGEONS

Date_____

ASSIGNMENT AND RELEASE:
I hereby assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the physician to release any medical information required to process this claim.
I authorize my provider's office to contact me by telephone to remind me of my appointments.
I authorize Saint Agnes Health to download my current medications for purposes of insurance payment.
I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities
I hereby consent to treatment by my Saint Agnes Health provider(s). I authorize Saint Agnes Health to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general healthcare operations, which may include use of an electronic health information exchange
I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws
I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.
I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occured prior to the date of the revocation will not be affected.
By signing this consent, I authorize **St Agnes Hospital** and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:
Name:_____ Relationship:_____

Method of Communication:_____

Name:_____ Relationship:_____

Method of Communication:_____

May we contact you regarding your protected health information, health status, appointments, and test results?

_Yes, you may contact me by e-mail; my address is:_____

_No, do not contact me by email for this purpose.

_Yes, you may contact me by phone; my daytime phone numbers are:
( )_____-_____ ( )_____-_____

_Yes, you may contact me at the following fax number ( )_____-_____
May we leave a message regarding your protected health information at the numbers you provided above?
__Yes __No

Signed_____ **Date:**_____