Patient's Personal History & Health Assessment Date: ____________

Patient Name: ______________________ **D.O.B.** ______________ **Gender:** __________

Email Address: ____

Last 4 digits SSN: ______________ **Race:** ______________ **Language:** ______________

Patient Street Address: ____

City: ______________________ **State:** ______________ **Zip Code:** __________

Home Phone: (______) ______________________ **Cell Phone: (_______)** ______________

Communication Preference (Circle) **Email** **US Mail** **Home phone** **Cell phone** **Work**

Employer: ______________________ **Employer Phone: (______)** ______________

Emergency Contact Name: ______________________ **Relationship:** ______________

Phone: (_______) ______________________ **Work: (_______)** ______________

Date of Last Physical Exam:______________________ **Physician:** ______________

Local Pharmacy Name: ____

Mail Order Pharmacy Name: ____

Medical Equipment (circle all that apply)

Do you use: Cane Walker Wheelchair Oxygen Nebulizer Hearing Aid

Do you use Glasses? Yes No Date of last eye Exam? ____________ Eye Doctor:______________________

Religion: ______________________________________ Number of Children______________

Marital Status (circle)

Married Domestic Partner Single Divorced Separated Widowed Lives Alone

Immunizations (circle if had and/or up-to-date)

Pneumococcal Measles/Mumps/Rubella Tetanus Influenza Shingles COVID RSV

Family History		Alive	Dead (age)	Health Problems/ Cause of Death
Mother				
Father				
Brother				
Sister				

Living Arrangements

	Yes	No
Do you own your home?	☐	☐
Do you rent your home?	☐	☐
Do you have a will?	☐	☐
Do you have a living will or advanced directive? (please provide copy)	☐	☐
Do you need other legal assistance?	☐	☐

Personal Habits

	Yes	No
Have you ever smoked tobacco or vaped?	☐	☐
Are you a regular smoker now?	☐	☐

Number of cigarettes/cigars per day, or how often do you vape: ________________________/day

How long have you been smoking? ___________________________ years

Check if you regularly drink alcohol: Social/ occasional drinker ☐

Hard liquor	1-3 oz. per day	☐	Over 3 oz. per day	☐		
Beer	1 bottle per day	☐	2 bottles	☐	3 or more	☐
Wine	1 glass per day	☐	2 glasses	☐	3 or more	☐
Do you drink coffee?	No	☐	Yes, 1-2 cups/day	☐	3+ cups	☐

Do you exercise? Rarely ☐ Occasionally ☐ Regularly ☐

Have you used any of the following:

Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other ☐

Lifestyles (optional)	Yes	No
Are you sexually active?		
If yes, please list sexual preference(s):		
Partner same sex		
Partner opposite sex		
Partners of both sexes		
Do you consistently use contraceptives?		

Activities of Daily Living	Yes	No
Do you use a catheter for urine?		
Do you have a problem using the toilet? (for urination bowel movement)		
Do you drive?		
Occupational		
Are you presently employed?		
Does or did your work involve unusual work, exposure to dust, noise, radioactivity etc.?		
Are you limited at work because of your disability?		
Are you retired?		

Types of work you have done:

____

____

____

Social History

Have you recently lived or traveled outside the U.S.?

Yes ☐ No ☐

Do you eat less than three meals a day?

Yes ☐ No ☐

Do you have special food customs or restrictions?

Yes ☐ No ☐

Do you use any community services now?

Yes ☐ No ☐

Check if you have/had any of the following illnesses. If unsure, leave blank:

Condition/Illnesses	Self	No	Relative
Alcohol overuse			
Allergies (other than medication)			
Anemia			
Arthritis			
Asthma			
Bleeding Tendency			
Cancer			
CVA/TIA			
Colitis			
Heart Disease (CHF, CAD,MI)			
Depression/Anxiety			
Diabetes			
Dialysis			
Emphysema/COPD			
Epilepsy			
Frequent Kidney/Bladder infection			
Frequent Lung Infections			
Gallbladder Disease			
Cardiac Arrhythmias/ pacemaker			
Gout			

Condition/Illness	Self	No	Relative
Heart Attack			
High Cholesterol			
Hepatitis			
High Blood Pressure			
Intestinal Polyps			
Jaundice			
Leukemia			
Headaches			
Nervous Break Down			
Radiation or Chemotherapy			
Rheumatic Fever			
Sexually Transmitted Disease			
Sickle Cell Anemia			
Stomach Ulcers			
Stroke			
Suicide Attempt			
Thyroid			
Tuberculosis			
Osteoporosis/Fracture history			
Sleep Apnea			

Operations: List and indicate approximate year

____

____

____

____

____

Serious Injuries/ Hospitalizations: (other than the above) List and indicate approximate year

____

____

____

Specialists/Other Providers: List name and specialty

____

____

____

____

____

____

Medications:

Do you take the following:

- ☐ Aspirin, Bufferin, Anacin, Tylenol or similar product
- ☐ Motrin, Advil, Aleve
- ☐ Vitamins
- ☐ Other prescription or over the counter drugs

List each drug, its amount and how often you take it:

____
____
____
____
____
____
____
____
____
____
____
____

PLEASE BRING ALL YOUR MEDICATION YOU'RE TAKING TO EVERY APPOINTMENT!

Are you allergic to any medications? Yes No

If yes, please list the medications and the reaction you had with them:

____
____
____
____
____
____

Do you have any environmental or food allergies? Yes No

If yes, please list them and the reaction you had to them:

____
____
____
____
____
____

Review of Systems:

Have you experienced any of these symptoms in the past ***month***?

General:	Yes	No
Fatigue?		
Increased thirst or drinking fluids?		
Unusual weight gain or loss?		
Cardiovascular	**Yes**	**No**
Pain or pressure in your chest?		
Irregular or fast heartbeat?		
Swelling in your feet or ankles?		
Cramps in your calf muscles when you walk?		
Have you been told your EKG was abnormal?		
Do your fingers or toes ever get cold, become numb, or get very white or bluish?		
Central Nervous System	**Yes**	**No**
Dizziness or lightheadedness?		
Frequent headaches?		
Recent fainting or lost consciousness?		
Trouble remembering recent events?		
Convulsions or seizures?		
Wanting to commit suicide?		
Hearing voices or hallucinations?		
Eyes	**Yes**	**No**
Pain in your eyes?		
Glaucoma or cataract(s)?		
Changes in your vision?		
Seeing halos around lights?		
ENT: (Ear, Nose, Throat)	**Yes**	**No**
Trouble hearing?		
Ringing or buzzing in your ears?		
Earaches or discharge from your ears?		
Drainage down the back of your throat?		
Frequent or severe nosebleeds?		
Persistent hoarseness?		
Gastrointestinal	**Yes**	**No**
Changes in your eating habits?		
Trouble swallowing?		
Indigestion or heartburn?		
Vomiting blood?		
Constipation?		
Frequent loose stools or diarrhea?		
Skin	**Yes**	**No**
Changes in skin color?		
Rashes or itching?		
New or changing lesions or moles?		
Sores or wounds that do not heal?		
Genitourinary	**Yes**	**No**
Urinary burning?		
Urinary frequency?		
Urinating at night?		
Urinary incontinence when you cough/sneeze?		
Blood in your urine?		
Have you ever had a vasectomy, tubal ligation, or hysterectomy?		
Have you ever had herpes?		
Men Only: Do you have prostate gland trouble?		
Musculoskeletal	**Yes**	**No**
Joint pain or stiffness (arthritis)?		
Back or neck pain?		
Trouble walking or with your hip/knee joints?		
Respiratory	**Yes**	**No**
Frequent colds or pneumonia?		
Constant or bothersome cough?		
Blood when you cough?		
Difficulties breathing?		
Wheezing?		
Women Only	**Yes**	**No**
Have you ever been pregnant? If yes, total number of pregnancies: ____________		
Lumps in your breast?		
Abnormal vaginal bleeding or discharge?		
Have you gone through menopause?		
Do you have any prolapse(falling out)of the vagina or uterus?		

PREVENTATIVE HEALTH:

Date of last Pap Smear: ______________________ OBGYN/Provider: ______________________

Date of last Mammogram: ______________________ Location: ______________________

Date of last Bone Density: ______________________ Location: ______________________

Date of last Colonoscopy: ______________________ Gastroenterologist: ______________________

PAIN ASSEESSMENT:

PAIN: YES _____ NO_____ LOCATION:______________________

COMMENTS: ______________________

____

____

____

____

TREATMENT PLAN: ______________________

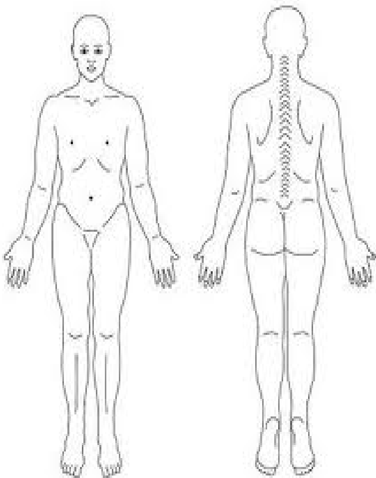
____

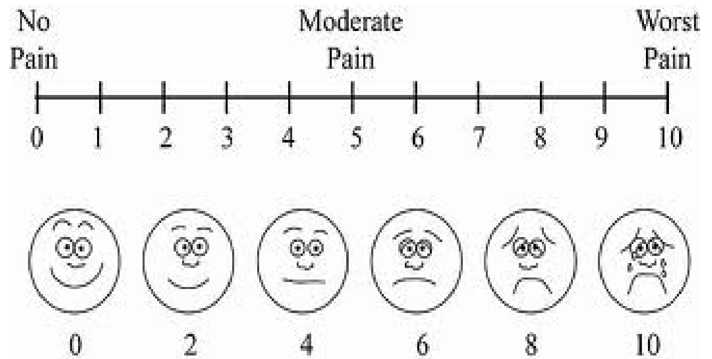
____

____

____

Please draw where your primary pain is located using the diagram below:





CONSENT FOR TREATMENT

I HEREBY CONSENT TO AND AUTHORIZE A PHYSICIAN AND/OR ANY HEALTH CARE PROFESSIONAL AT BROWARD FAMILY MEDIAL GROUP TO PERFORM A PHYSICIAL EXAMINATION, DIAGNOSTIC PROCEDURE(S) AND TO PRESCRIBE A THERAPEUTIC REGIMEN. I HEREBY AUTHORIZE THE PHYSIAN(S) OF BROWARD FAMILY MEDICAL GROUP TO RELEASE/COLLECT INFORMATION INCLUDING DIAGNOSIS ACQUIRED IN THE COURSE OF MY EXAM TO/FROM ANY HEALTHCARE FACILITIES, PHYSICIANS, OR INSURANCE CARRIERS.

PATIENT SIGNATURE: ____

DATE: ____

PRIVACY PRACTICES ACKNOWLEDGEMENT

A COPY OF THE PRIVACY PRACTICES IS POSTED IN THE LOBBY AND I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW IT. If you would like a copy for your records, it is available upon request.

PATIENT SIGNATURE: ____

PATIENT NAME: ____

DATE: ____

PATIENT DATE OF BIRTH: ____

INSURANCE INFORMATION AND RELEASE

Patient Name: ____

Subscriber's Name/Relationship to Patient (if not patient): ______________________________

Date of Birth: ______________________Social Security Number: __________________________

Insurance Company: ____

Member ID: ____________________________ Group #:______________________________

Is the patient covered by additional insurance? _______Yes _______No

Secondary Insurance:____

Member ID: ____________________________ Group #:______________________________

Assignment of Benefits/ Financial Responsibility
I certify that I have insurance with ___________________________, and hereby assign all medical and surgical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other auto/health/medical plan, to issue payment check(s) directly to Broward Family Medical Group for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance.

Authorization to Release Information
I hereby authorize Broward Family Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments for the purpose of obtaining payment; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Medicare/Medigap Authorization
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Broward Family Medical Group, for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or for related services.

____ ________________________
Signature of Patient, Guardian or Personal Representative Date

____ ________________________
Printed Name of Patient, Guardian or Personal Representative Relationship to Patient

2701 NE 14th Street Causeway, Suite 5, Pompano Beach, FL 33062
Phone: (954) 545-1560 Fax: (954) 545-1561

Waskin
☐ Routine
☐ Archive
☐ STAT

2701 NE 14TH Street Causeway, Ste 5, Pompano Beach, FL 33062
Fax: 954-545-1561

CONSENT TO RELEASE MEDICAL, PSYCHIATRIC, AIDS/ARC/HIV TESTING, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

1. I hereby authorize my provider at Broward Family Medical Group:
   - To RELEASE copies of my medical records to:____________________________________
   - To RECEIVE copies of my medical records from: __________________________________
   ____
   ____

2. I understand that my records may contain information pertaining to my diagnosis or treatment of my Medical, Psychiatric, AIDS/ARC/HIV Testing, Alcohol or Drug Abuse Condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

____ ________________________
Signature Date

3. Information to be released/requested: (please circle)
   OFFICE NOTES LABS X-RAYS EKG HOLTER ECHO
   D/C SUMMARY OP NOTES EGD/COLONOSCOPY ALL MEDICAL RECORDS
   DATES OF SERVICE (S): ____

4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.

5. This consent expires in: _____________________________ (if not specified, continues indefinitely)

6. Broward Family Medical Group is released from any legal responsibility of liability for the release of the above information to the extent indicated and authorized herein.

Signed:____ Date: _________________________
Print Patient Name: ______________________________________
Last 4 digits SS#: ____ Date of Birth: ___________________

CANCELLATION/ NO SHOW AND OFFICE POLICIES

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will allow another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $50.00 cancellation fee.

Patients who do not show up for their office or blood work appointment without a call to cancel will be considered a NO-SHOW. Patients who no-show three (3) or more times in a 12-month period may be dismissed from the practice and denied any future appointments.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before rebooking the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

This practice is a primary care office and does not routinely prescribe controlled substances. Patients who are prescribed controlled medications per the provider's discretion will be subject to a separate controlled-substance policy.

Furthermore, verbal abuse or abusive behavior towards staff or other patients is strictly prohibited and grounds for immediate discharge from the practice.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the office manager at (954) 545-1560.

Please sign that you have read, understand, and agree to this policy.

Patient Name: ____ Date of Birth: ___________________

Signature: ____ Date: __________________________

Signature of Patient or Patient Representative