

# Past Medical History Form

## Male

M- Mother	
F- Father	
MGM- maternal grand mother	
MGF- maternal grandfather	
PGM- paternal grandmother	
PGF- paternal grandfather	
MA- maternal aunt	B- Brother
PA- paternal aunt	SIS- Sister
MU- maternal uncle	SON- son
PU- paternal uncle	DA- daughter

How did you hear about us? \_\_\_\_\_

	<b>Personal History</b>	<b>Family History</b>	
<b>X</b>	<b>Disease</b>	<b>Date of Diagnosis/ Explanation</b>	<b>Which family member- use key</b>
	High blood pressure		
	High cholesterol		
	Abnormal heart rhythm		
	Heart murmur		
	Peripheral arterial disease		
	Congestive heart failure		
	Heart attack		
	Other problem with heart or arteries/veins		
	Asthma		
	Allergies		
	Blood clot in lung		
	Pulmonary high blood pressure		
	Sleep apnea (stop breathing when asleep)		
	Excessive snoring		
	Chronic sinus issues		
	COPD		
	Emphysema		
	Other lung problems		
	Stomach ulcer		
	Chronic heartburn		
	Irritable bowel syndrome		
	Crohn's disease		
	Ulcerative colitis		
	Chronic constipation		
	Hemorrhoids		
	Pancreatitis		
	Liver disease/ Hepatitis		
	Gallstones		
	Diverticulitis		
	Other problems with your digestive tract		
	Hypothyroidism		
	Hyperthyroidism		
	Diabetes		
	Osteopenia/ Osteoporosis		
	Other endocrine issues		

<b>X</b>	<b>Disease</b>	<b>Date of diagnosis/ Explanation</b>	<b>Which Family Member</b>
	Warts		
	Eczema		
	Psoriasis		
	Abnormal moles		
	Seizures		
	Migraines		
	Chronic headaches		
	Stroke or TIA		
	Dementia		
	Other neurological problems		
	Urinary leakage		
	Endometriosis		
	Fertility Problems		
	Uterine Fibroids		
	Poly cystic ovarian disease		
	Sexually transmitted disease		
	Irregular periods		
	Kidney stones		
	Gout		
	Arthritis		
	Rheumatoid arthritis		
	Fractures		
	Lupus		
	Blood transfusion		
	Clotting/ Bleeding issues		
	Anemia	What kind	
	Sickle cell trait/ Disease		
	Thalassemia		
	Anxiety		
	Bipolar Disorder		
	Depression		
	ADD/ADHD		
	Substance abuse/inc. alcohol		
	Cancer	What type/ treatment	
	Other medical issues not listed		

## Surgeries

<b>X</b>	<b>Surgery</b>	<b>Date</b>	<b>X</b>	<b>Surgery</b>	<b>Date</b>
	Tonsillectomy			Hysterectomy	
	Tubes in ears			Tubal ligation	
	Appendectomy			Cataract R/L	
	Gallbladder removal			Cosmetic	
	Back Surgery			Heart Surgery	
	Joint Surgery			Hernia	
	Joint replacement			C-section	
	Other			Other	

## Procedures

Have you ever had:

<b>X</b>	<b>Procedure</b>	<b>Date</b>	<b>X</b>	<b>Procedure</b>	<b>Date</b>
	Heart catheterization			Mammogram	
	Colonoscopy			Bone Density Scan	
	Upper scope (EGD)			Prostate Check or PSA	
	Echocardiogram				

## Social

<b>Occupation:</b>	
<b>Highest level of education:</b>	
<b>Marital Status:</b>	Single Partner(girlfriend/boyfriend) Engaged Married Divorced Widowed
<b>Sexual Orientation: Do you have sex with:</b>	Women Men Both
<b>Number of children:</b>	<b>Biological:</b> <b>Stepchildren:</b> <b>Adopted:</b>
<b>Last tetanus shot:</b>	
<b>Do you live by yourself or with others?</b>	
<b>Exercise level?</b>	None    1-2/week    3-4/week    5-7/week
<b>How many alcoholic drinks per week?</b>	Never    Rare    0-3    4-6    7-10    11-14    >14
<b>Have you ever had a problem with alcohol use?</b>	Y    N
<b>Diet</b>	Regular    Vegetarian    Vegan    Gluten-free    Other
<b>General Stress Level</b>	Low    Medium    High
<b>Have you ever smoked?</b>	<b>Current?</b> <b>How much?</b> <b>How long?</b>
	<b>Past?</b> <b>How much?</b> <b>How long?</b>
<b>Smokeless tobacco?</b>	<b>Cur/Past?</b> <b>How much/</b> <b>How long?</b>
<b>Regular use of marijuana?</b>	
<b>Other illicit drugs?</b>	<b>Any problems with controlled substances?</b>
<b>Past/Present?</b>	<b>Like prescription medications?</b>
<b>Any problems with drug use?</b>	Y    N
<b>Do you drink caffeine? How much per day?</b>	<b>Soda? (Diet) #    (Sugar)#    Coffee #    Tea#    Energy Drinks#</b>

## Safety

Do you use seatbelts regularly?	
Do you use sunscreen regularly?	
Do you have guns present in the home?	If so are they locked away from children?
Do you have a smoke alarm at home?	
Do you wear a bike helmet?	
Any history of domestic violence?	
Any history of sexual violence?	

## Personal

Do you have any pets?
What do you like to do for fun or pass time?
Other things that you would like to share about yourself?

## Medication Allergies/Food Allergies/Contact Allergies

Medication/Food/Contact	Reaction

## Current Medications

Please list reason for taking each medication

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

## Vitamins/ Supplements

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

## Past Medications

Medication	Reason for taking	Medication	Reason for taking

## Health Goals

Please list health goals that you would like to reach for yourself

1.
2.
3.
4.
5.

## Male Review of Systems

**Please circle recent symptoms and use lines below to explain. List #.**

1. **Constitutional:** fatigue, poorly (malaise), fever, night sweats, weight gain or loss that doesn't make sense
2. **Eyes:** dry eyes, irritation, vision change, discharge from eyes, foreign body sensation in eyes
3. **Ears:** ear pain, ear congestion, ears popping, discharge from the ears, difficulty hearing
4. **Nose:** nasal congestion, nasal discharge, post-nasal drip, maxillary sinus pain, frontal sinus pain
5. **Mouth/Throat:** sore throat, snoring, mouth ulcer, teeth abnormalities
6. **Cardiovascular:** chest pain, shortness of breath when lying down, rapid or irregular heartbeat (palpitations), excessive sweating
7. **Respiratory:** cough, wheezing, shortness of breath
8. **Gastrointestinal:** heartburn, nausea, vomiting, diarrhea, constipation, abdominal pain, bloating
9. **Genitourinary:** pain with urination, urine leakage, foul-smelling urine, increased urinary frequency, blood in urine, change in strength of urine stream, unable to completely empty bladder, erectile dysfunction
10. **Musculoskeletal:** muscle aches, muscle weakness, joint pain, back pain
11. **Skin:** abnormal moles, rash, abnormal skin lesions, breast lump, change in the breast skin
12. **Neurologic:** headaches, dizziness, weakness, numbness
13. **Psych:** depression, anxiety, sleep disturbances, mania, feeling unsafe in relationship, alcohol or substance abuse, difficulty falling asleep, early morning waking, not feeling rested after adequate sleep, loss of interest in activities, loss of pleasure from usual activities, inappropriate feelings of guilt, decreased energy, decreased motivation, decreased concentrating ability, abnormal appetite, feeling like hurting self, feeling so badly that you wouldn't mind if you died in your sleep, feeling actively suicidal, feeling emotionally detached, feeling unique and all-powerful (grandeur), disturbing or unusual thoughts, feelings, or sensations, decreased need for sleep, impulsive behavior, pressured speech, causing anger in friends and family
14. **Endocrine:** change in weight distribution, increased hair loss, excessively dry skin, change in color of skin, feelings of weakness and fatigue, feeling more hot or cold than others, hot flashes, abnormal hair growth,
15. **Hematologic/Lymphatic:** swollen glands, abnormal bruising
16. **Allergies:** runny nose, sinus pressure, itching, hives, frequent sneezing


# Highlands Health For Life

## Confidential Patient Information

**Please Print:**

How did you hear about us? \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Present Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Marital Status \_\_\_\_\_

Can we leave medical messages on your voice mail? Yes No Which phone? \_\_\_\_\_

E-Mail \_\_\_\_\_ Patient Soc. Sec. # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Pharmacy # \_\_\_\_\_

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**In case of emergency please notify:**

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Telephone 1) \_\_\_\_\_ 2) \_\_\_\_\_

Parent or Guardian (if patient is a child) \_\_\_\_\_

Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Work # \_\_\_\_\_

Parent or Guardian (if patient is a child) \_\_\_\_\_

Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Work # \_\_\_\_\_

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**Insurance Info**

Insurance Company \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Name of Policy Holder (specify primary or secondary insurance) \_\_\_\_\_

Birth Date of Policy Holder \_\_\_\_\_

SSN # of Policy Holder \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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# Highlands Health For Life

## Whitney Kennedy M.D.

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Name of Practice: Highlands Health For Life

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

### Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have read Highlands Health For Life's Notice of Privacy Practices

\_\_\_\_\_  
Signature of patient or patient representative

\_\_\_\_\_  
Date

### Documentation of Good Faith Efforts To obtain patients acknowledgement that they received provider's Notice of Privacy Practices

(For use when patient cannot obtain acknowledgement)

The patient presented to the office on \_\_\_\_\_ and was provided with a copy of Highlands Health For Life's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the notice. However, such acknowledgement was not obtained because of the following reason:

- Patient refused to sign
- Patient was unable to sign or initial because:  
\_\_\_\_\_  
\_\_\_\_\_
- The patient had medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- Other reason (describe below):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Employee Completing Form

\_\_\_\_\_  
Date

**Highlands Health For Life**  
**Whitney Kennedy M.D.**

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**PAYMENT TERMS AND AGREEMENTS**

I, the undersigned, in consideration for services rendered to the patient by Highlands Health For Life, understand and agree to the following:

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1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which Highlands Health For Life is under contract to file directly.
  2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Highlands Health For Life. I will be responsible for any co-payment, deductible or service not covered by my insurance provider. If I do not have insurance coverage for services rendered by Highlands Health For Life, I agree to pay all charges resulting from such services.
  3. I hereby authorize Highlands Health For Life to file with my insurance carrier and I assign payment of medical benefits to Highlands Health For Life.
  4. I authorize release of any and all medical records and information necessary to process any claim generated by services I receive in this office.
  5. I will keep my account current as to charges for which I am responsible. In the event that I fail to pay charges, Highlands Health For Life is entitled to take whatever action necessary to collect such charges and I will be responsible for reasonable attorney's fees and costs incurred as a result of such collection.
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My signature below indicates that I have read and agree to the terms set above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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