



Dear Patient:

The following questions are designed to collect important information about you and your health. Answering these questions before your office visit will allow more time for a detailed discussion with your provider. Please complete all questions.

PATIENT INFORMATION & PREFERENCES *(Please print or type)*

Last Name: _____ First Name: _____ M.I. _____

Preferred Name: _____ Date of Birth: ____ / ____ / ____

Primary Insurance: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Number: _____

YOUR MAJOR HEALTH CONCERNS OR QUESTIONS

What matters most to you about your health? _____

Describe briefly the major medical problem(s) or question(s) that you have: _____

List below all the medications that you take regularly or have taken regularly in the past month (including aspirin products, vitamins, birth control pills, etc.):

Drug	Drug Strength	How often you take the drug each day	Length of time you have taken the drug



Patient Name (Print): _____ Patient DOB: ____/____/____

Do you need medication refills today? Yes No If yes, please list below:

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Are you having problems affording your medications? Yes No

Allergies: List any drug allergies (if any, briefly describe the reaction): _____

Are you allergic to antibiotics (such as penicillin or sulfa)? Yes No

Please answer the following questions regarding your Sexual Orientation and Gender Identity:

Birth Sex: ___ Male ___ Female ___ Unknown

What is your Gender Identity:

- ___ Male ___ Female
- ___ Female-to-Male (FTM) / Transgender Male/Trans Man ___ Male-to-Female (MTF) / Transgender Female/Trans Woman
- ___ Genderqueer, neither exclusively male nor female ___ Other: _____
- ___ Choose not to disclose

What is your Sexual Orientation:

- ___ Lesbian, gay, or homosexual ___ Straight or heterosexual ___ Bisexual
- ___ Do not know ___ Choose not to disclose ___ Other: _____

What is your current relationship status?

- ___ Single ___ Partner ___ Married

Please place a check mark next to the highest level of education you obtained in school:

- ___ Elementary ___ High School ___ College ___ Other: _____

How do you prefer to learn new information? (circle one)

- Doing / Demonstration Reading / Written Materials Watching / Video or Presentations



Patient Name (Print): _____ Patient DOB: ____/____/____

PAST MEDICAL HISTORY

Place a check mark on the line next to the illness or illnesses that you currently have or have had in the past:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Nervous stomach |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Spastic colon |
| <input type="checkbox"/> Depression or other mental illness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Yellow jaundice |

Serious past injuries (describe the type of injury and approximate dates of occurrences):

Previous surgery (Place a check mark on the short line next to the type of surgery you have had. On the long line, indicate the approximate date of surgery.):

- | | |
|---|---|
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Breast surgery _____ | <input type="checkbox"/> Hysterectomy _____ |
| <input type="checkbox"/> Eye surgery _____ | <input type="checkbox"/> Open heart surgery _____ |
| <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Stomach or colon surgery _____ |
| <input type="checkbox"/> Other surgery: _____ | |

Previous hospitalizations (other than surgery):

Hospital	Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Patient Name (Print): _____

Patient DOB: ____/____/____

HEALTH MAINTENANCE

Vaccines

When was your last tetanus booster? _____

Have you had a flu (influenza) vaccine in the last 12 months? Yes No

If yes, please tell us when and where, if known: _____

Have you had a pneumonia vaccine in the last 12 months? Yes No

If yes, please tell us when and where, if known: _____

Have you ever had a shingles vaccine? Yes No

If yes, please tell us when and where, if known: _____

Screenings

Do you have eye exams regularly? Yes No Where and when was your last eye exam? _____

Do you have dental exams regularly? Yes No Where and when was your last dental exam? _____

Have you ever had a colorectal cancer screening (colonoscopy)? Yes No

If yes, please tell us when and where, if known: _____

What is your usual weight? _____ What was your approximate weight one year ago? _____ What is your present weight? _____

WOMEN:

Name and address of your GYN Provider: _____

Have you had a "Pap" smear in the last two years? Yes No

Have you ever had a Mammogram? Yes No If yes, where and when was your last scan? _____

Have you ever used birth control pills? Yes No

Obstetrical History: Number of pregnancies: _____ Number of deliveries: _____

Please tell us about any other Specialists you see: List the name, location, and how often you see them:



Patient Name (Print): _____

Patient DOB: ____/____/____

FAMILY HISTORY

Is your mother living? Yes No (cause of death and age at death _____)

Is your father living? Yes No (cause of death and age at death _____)

Have any family members, either living or dead, ever had any of the following diseases? If yes, place a check mark on the short line next to the illness. On the long line next to the illness, put the name of the family member or the initial code letter of the family member that had the illness. The following code initials may be used:

Mother [M]

Brother [B]

Aunt [A]

Father [F]

Child [C]

Uncle [U]

Sister [S]

Grandparent [GP]

Cousin [CS]

(For example: If one of your grandparents and a cousin had tuberculosis: Tuberculosis GP, CS)

Family Member

Family Member

____ Alcoholism _____

____ Heart Attack _____

____ Cancer _____

At what age(s)? _____

____ Breast cancer _____

____ High blood pressure _____

____ Colon cancer _____

____ Kidney disease _____

____ Ovarian cancer _____

____ Osteoporosis _____

____ Colitis _____

____ Tuberculosis _____

____ Diabetes _____

____ Other _____

SOCIAL HISTORY AND HABITS

Do you drink alcoholic beverages (wine, beer, liquor, etc.)? Yes No

If yes, how many alcoholic beverages do you have on average in a week? _____ per week

Do you smoke? Yes No

If no, have you ever smoked? Yes No

Please tell us how many years you have/had been a cigarette smoker: _____ year(s)

Have you ever tried to quit smoking? Yes No

How many days per week do you exercise for at least 20 minutes? _____ days per week

Are you sexually active? Yes No

What method of contraception do you use? _____ Birth control pill _____ Condom _____ Diaphragm

____ Other: _____

Have you ever been diagnosed with a sexually transmitted disease? Yes No



Patient Name (Print): _____

Patient DOB: ____/____/____

ASSIGNMENT OF INSURANCE BENEFITS

Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Coastal Medical, I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY MY BENEFIT PLAN.

Patient's
Signature

_____/_____/____

Date

Have you designated anyone to function as your legal guardian or decision maker (by completing a "living will" or "power of attorney" form) in the event that you are unable to make decisions regarding your health care?

Yes No

If "YES," please write the name, address, phone number, and relationship of that individual:

Name: _____

Address: _____

Relationship to you: _____ Phone: _____

If "NO," please ask your physician about this.

I have reviewed the information in this questionnaire and verified that the information is accurate.

Patient's Signature

If questionnaire was completed by someone other than the patient:

Relationship to patient: _____

Patient's signature

PHYSICIAN'S NOTES:



CONTACT INFORMATION FORM

Patient Name: _____ **DOB:** ____ / ____ / ____

Emergency Contact Information

Please complete all information below. In the event of an accident or other emergency, we will use this information to notify your preferred contacts:

Primary Contact Person:

Name: _____ DOB: ____ / ____ / ____

Relationship to patient: _____

Are they a Coastal Medical Patient: Yes No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Contact Person:

Name: _____ DOB: ____ / ____ / ____

Relationship to patient: _____

Are they a Coastal Medical Patient: Yes No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Permission to Discuss

I, the undersigned, hereby give Coastal Medical permission to discuss my medical information with:

Name #1: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name #2: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list any exclusions to discuss such as AIDS, HIV, psychiatric disorders, history of treatment for drug or alcohol abuse:

Patient/Legal Guardian Signature: _____

Date: ____ / ____ / ____

You may update this information at any time.



Coastal Medical

Lifespan. Delivering health with care.®

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

City: _____ State: _____ Zip code: _____

Records to be released to: (Please complete in Full)

To: _____

From: Coastal Medical (Please indicate proper selection below)

Address: _____

All Coastal Medical Practices/Providers

City: _____ State: _____ Zip Code: _____

*Specific Coastal Practice/Provider: _____

*Note: If you indicate a specific Coastal Practice/Provider, you will only receive records from that provider and/or practice. If you were seen by one of our specialists or at C365, these notes would **NOT** be included.

Delivery Method: Paper _____ Electronic: _____ (For Patient request)

* **Specific Dates of Service(s) Requesting** _____ To _____

Progress/Consult notes

Laboratory Reports

X-Ray Reports

Abstract Records (Progress notes/Tela visits, Lab reports, Xray reports, Special Studies)

For continuation of care, we provide last 2 years

Complete Record (Last 10 years)

Reason for Request: _____

This authorization includes permission to transfer information regarding Aids, HIV, Psychiatric disorders, and history of treatment for drug and alcohol abuse.

Have you seen a behavioral health specialist in our office?: Yes If yes, by whom?: _____ No

Do you authorize the release of these records as well?: Yes No

I understand that behavioral health diagnoses and medication are included in my medical records and will be included in this release of Medical Records Information.

I understand that I may revoke this authorization at any time prior to an actual release of records made in good faith that occurred in reliance on this authorization.

This Authorization will automatically expire in 90 days from the date signed below.

This Authorization does NOT allow an agency receiving records from further distributing them without additional written consent of the patient.

Signed: _____ **Date:** _____

If signed by Legal guardian or representative, please include the legal documents providing your authority.

* Requests for patient's medical records will be billed to the patient according to state regulations