PEARL
Pearl Medical Practice
Primary Care

PATIENT HEALTH HISTORY FORM

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

PATIENT NAME: _____ **DATE OF BIRTH**: _____

How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check/circle any current symptoms you have.

Constitutional
____ Unexplained weight loss/gain
____ Recent fevers/sweats
____ Unexplained fatigue/weakness
____ Recent chills/cold sweats

Cardiology
____ Chest pains/discomfort
____ Palpitations
____ Decreased exercise tolerance

Dermatology
____ Rash
____ New or change in mole

Endocrinology
____ Cold/heat intolerance
____ Increase thirst/appetite

ENT
____ Change in hearing
____ Congestion
____ Sinus pain
____ Sore throat

Hematology/Lymph
____ Unexplained lumps
____ Easy bruising/bleeding

Genitourinary
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penis or vagina
____ Concern with sexual functions

Gastroenterology
____ Heartburn/reflux
____ Bloody stools
____ Change in bowel movement
____ Nausea/vomiting/diarrhea
____ Pain in abdomen

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain
____ Weakness
____ Swollen joints

Neurology
____ Memory loss
____ Headaches
____ Fainting
____ Numbness/tingling in hands/feet
____ Loss of balance

Ophthalmology
____ Change in vision
____ Eye pain

Psychology
____ Anxiety/stress
____ Sleep problems

Respiratory
____ Cough/wheeze
____ Coughing blood
____ Short of breath with exertion
____ Pain with breathing

Women
____ No periods
____ Heavy periods
____ Painful periods
____ Irregular periods
____ Unusual vaginal bleeding
Date of last period: _____
Menopause at age: _____

PEARL
Pearl Medical Practice
Primary Care

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day?

Pharmacy Name: _____ **Address/ Phone Number:** _____

ALLERGIES: Do you have allergies or reactions to:

Medications	Reaction	**Foods**	Reaction
_____		_____	
_____		_____	
_____		_____	

IMMUNIZATIONS: Date of most recent record.

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____
Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE: Date of most recent record.

Cholesterol _____ Abnormal? □ Yes □ No
Colonoscopy _____ Abnormal? □ Yes □ No
Bone Density Scan _____ Abnormal? □ Yes □ No
Women: Mammogram _____ Abnormal? □ Yes □ No Pap Smear _____ Abnormal? □ Yes □ No
Men: PSA (prostate) _____ Abnormal? □ Yes □ No

MEDICAL HISTORY: **SURGICAL HISTORY:**

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?	Surgeries:	Year of Surgery	Reason for Surgery

PEARL
Pearl Medical Practice
Primary Care

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____
Cancer, specify type _____
Heart disease _____
Depression/suicide _____
Genetic disorders _____
Diabetes _____
Kidney disease _____
High cholesterol _____
High blood pressure _____
Stroke _____
Bleeding/clotting disorder _____
Asthma/COPD _____
Anxiety _____
Other: _____

SOCIAL HISTORY:

Tobacco Use

Cigarettes: □ Never □ Quit Date _____
□ Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ Yes □ No # drinks/week _____
Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use

Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No

Sexual Activity

Sexually active: □ Yes □ No □ Not currently
Current sex partner(s) is/are: □ male □ female
Birth control method: _____ □ None needed
Have you ever had any sexually transmitted diseases (STDs)?
□ Yes □ No
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Caffeine Intake: □ None □ Coffee/tea/soda _____cups/day
Weight: Are you satisfied with your weight? □ Yes □ No
Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? □ Yes □ No
Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____

SOCIOECONOMICS:

Occupation: _____
Employer: _____
Marital Status: □ Single □ Partner/Married □ Divorced □ Widowed □ Other: _____
Number of children/ages: _____

WOMENS HEALTH HISTORY

Pregnancies: _____
Deliveries: _____
Abortions: _____
Miscarriages: _____
Age at start of periods: _____ Age at end of periods: _____

PEARL
Pearl Medical Practice

Patient Name: _____

Gender at birth (Circle One) Male Female **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____

Social Security Number: _____

Email address: _____

Marital Status:

- O Single
- O Married
- O Widowed
- O Divorced
- O Separated

Ethnicity

- O Hispanic or Latino
- O Not Hispanic or Latino
- O Other

Preferred Language

- O English
- O Spanish
- O Other: _____

Race

- O American Indian or Alaskan Native
- O Asian
- O Black or African American
- O Hispanic or Latino
- O Native Hawaiian or Other Pacific Islander
- O Patient Declined
- O White

PEARL
Pearl Medical Practice

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Insurance:

Primary Insurance: _____

Policy Holder: _____

Policy Holder's DOB: _____ ID Number: _____

Group Number: _____

Secondary Insurance: _____

Policy Holder: _____

Policy Holder's DOB: _____ ID Number: _____

Group Number: _____

1. I authorize payment of medical benefits to the provider's and release of all medical information necessary to process claims.
2. I authorize the release of medical information to and from the following:
   - primary care
   - referring physician
   - hospital
   - laboratory
   - diagnostic facilities
   - Psychiatric facilities/providers
   - Insurance companies/all payer sources

   As needed for evaluation, treatment and payment of services rendered.
3. I understand I am responsible for any denied or non-covered services, deductibles and all Co-pays.
4. I understand that my copays are due at the time of services; NO EXCEPTIONS.
5. I understand that it is my responsibility to bring current any past due balances.
6. I understand it is my responsibility to verify the providers in this group participate with my insurance company, if the providers do not participate, I will be responsible for all non-covered charges.
7. I agree to present my insurance cards and Photo ID at EVERY visit.

Patient Signature: _____

Date: _____

PEARL
Pearl Medical Practice

Authorization for Disclosure of Protected Health Information

This authorization will authorize Pearl Medical Practice to use and/or disclose certain protected health information that is in the practice's possession about the person named below.

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____

Signature of Legal Guardian: _____ **Relationship:** _____

I hereby authorize the use and/or disclosure of my protected health information as described below:

- __ History & Physical Examination
- __ Progress Notes
- __ Test Results
- __ Consultation Reports
- __ Operative Reports
- __ Entire Medical Records
- __ Other: _____

1. **My authorization applies to the information described above. Only this information may be used and/or disclosed pursuant to this authorization.**

2. **I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, mental or behavioral health or psychiatric care.**

3. **The authorized person (or entity) to request and receive the information indicated in this authorization is: _____.**

4. **The protected health information being use and/or disclosed under this authorization is for the following purpose (you may leave this blank if you are the patient or patient's legal guardian and the protected health information is being released to you).**

5. **I understand that I have the right to revoke this authorization, in writing at any time; by sending such written notification to Pearl Medical Practice. I understand that my request is not effective for actions already completed.**

6. **Unless otherwise revoked, I understand that this authorization will expire one year from the date signed.**

PEARL
Pearl Medical Practice

PEARL MEDICAL CONTROLLED SUBSTANCES AGREEMENT

I, _____, understand that individuals who are prescribed certain controlled substances including, but not limited to, narcotic pain medications, stimulants, benzodiazepine tranquilizers, and barbiturate sedatives, can abuse those substances or may allow abuse by others. These substances have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I understand that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this agreement. Furthermore, I understand that if I do not adhere to these strict rules or violate any term of this agreement; my provider may reduce my medication, discontinue my medication or **discharge me from the practice.**

Please INITIAL EACH LINE.

1. _____ (Please initial) I will inform my provider if I ever have or have had any history of substance abuse, and I will make them aware if any member of my family or household has a history of substance abuse. I am not undergoing treatment for substance dependence or abuse.

2. _____ (Please initial) I agree that I may be subject to an evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substances may be prescribed to me. I agree that the need to be evaluated by psychologists and/or psychiatrists may be revisited every 3-6 months thereafter while taking the medications. If I do not adhere, I will be in violation of this agreement and subject to discharge.

3. _____ (Please initial) I agree that all controlled substances must come from Pearl Medical Practice, unless specific written authorization is obtained from the office. If it is found that I received a prescription for narcotic medications from a source other than Pearl Medical Practice, I may be discharged, and any prescriptions for narcotic medication could be discontinued.

4. _____ (Please initial) I agree that only one pharmacy will be used for filling narcotic prescriptions. Should the need arise to change pharmacies; I will notify the office before I pick up any narcotic prescription. The pharmacy that I have selected is:

Name of Pharmacy: _____ **Location:** _____

5. _____ (Please initial) I will inform my other health care providers that I am taking controlled substances and that I have signed this agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

6. _____ (Please initial) I agree that Pearl Medical Practice staff can communicate with any other health care providers involved in my care, past or current, regarding any and all aspects of my treatment.

7. _____ (Please initial) I will not share, sell or otherwise let anyone else have access to these medications. **THE SHARING OF MEDICATIONS WITH ANYONE IS ABSOLUTELY FORBIDDEN BY THIS OFFICE AND IS PUNISHABLE BY LAW WHICH CAN INCLUDE HEAVY FINES AND PRISON TIME.**

PEARL
Pearl Medical Practice

8. _____ (Please initial) I agree that my narcotic medication is not for recreational use and I will not combine my narcotic medications with the consumption of alcohol. I will take it exactly as instructed by my provider. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without talking to my provider. **Failure to comply may result in immediate discharge from the practice.**

9. _____ (Please initial) I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from the practice.

10. _____ (Please initial) I understand that unannounced urine or serum toxicology screenings may be requested at any time and I agree to submit any specimen requested. I understand that I may **NOT leave the office waiting room *prior* to providing a urine sample**; leaving for any reason may result in not receiving your prescription as well as discharge from the practice. If I submit any altered/artificial urine for my drug screen, I may be discharged from the practice. If I do not agree with the initial findings, I understand that a confirmation of my results will be obtained by a licensed laboratory outside the practice. Until the confirmation is obtained, I may receive a reduction in my medication. There will be no retesting at my request until the confirmation has been obtained. If I request a retest, I agree to cover any costs not covered by my insurance. Failure to comply may be considered a violation of my narcotic agreement.

11. _____ (Please initial) I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt a referral for a substance abuse disorder assessment, and I will be discharged from the practice.

12. _____ (Please initial) I understand that a pill count may be required upon the provider's discretion. If called for a pill count, I agree to come in the office **that same day**. I agree to keep the office updated of my current phone number and address; accurate contact information is my responsibility. I also agree that if I do not respond to a requested pill count, this may be considered a violation of my narcotic agreement, which could result in the discontinuation of controlled substances as well as discharge from the practice.

13. _____ (Please initial) I understand that narcotic medications **will not be replaced** if they are lost, damaged, stolen or inaccessible. If I report my controlled substance medications lost, damaged, or stolen twice within a year, my narcotic medication may be discontinued.

14. _____ (Please initial) I understand that a prescription **will not** be given early for any reason, e.g. out of town, family emergency, etc. If I give advance notice to my pharmacist, national pharmacies can grant temporary permission to transfer my prescription to the location nearest my destination.

15. _____ (Please initial) I agree that if legal authorities have questions concerning my treatment for suspicion of violating the law for illegal drugs, these authorities may be given full access to my records regarding controlled substance administration.

16. _____ (Please initial) I will keep my scheduled appointments. If I need to cancel my appointment, I will do so a **minimum of twenty-four (24) hours before it is scheduled**. I understand that a cancelled or rescheduled appointment could result in a delay of my medication refill.

17. _____ (Please initial) I understand that it is my responsibility to make sure that I have enough medication to get through the weekend, holiday, or after hours and that all refill request require **five (5)-days-notice to my pharmacy**.

PEARL
Pearl Medical Practice

18. _____ (Please initial) I understand that any medical treatment is initially a trial, with the goal being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of my treatment, and continued prescriptions may be contingent on whether my provider believes that the medication usage benefits me.

19. _____ (Please initial) I understand that the possible complications of long-term narcotic therapy include: chemical physical dependence and addiction, constipation which should be severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and reduced sexual function. If I take more medication than is prescribed, a dangerous situation could result, such as coma, organ damage, or even death.

20. _____ (Please initial) *WOMEN ONLY*. I take responsibility to let my doctors know if I am pregnant. If I become pregnant, there are known and unknown risks to the unborn child. These include narcotic addiction of the infant and the possibility of the infant experiencing narcotic withdrawal after birth. I understand that my provider will help me find ways of controlling my pain without narcotics.

21. _____ (Please initial) I understand that my controlled substance administration at this office may be temporary. Should I require long term treatment that involves receiving controlled substances on an on-going basis or an exceptionally high dose of medication, I may be required to consult with a specialist for an evaluation of my condition(s).

22. _____ (Please initial) I agree to conduct myself in an agreeable manner while in the office or on Pearl Medical Care Center premises, and I agree to refrain from any unruly behavior, including raising my voice, offensive slurs or foul language or physical acts such as slamming or throwing items. This behavior constitutes a violation of this agreement and will result in immediate discharge and notification to the legal authorities. **Pearl Medical has a ZERO tolerance for belligerent behavior to staff or other clients; this behavior will result in discharge from the practice and notification to the authorities.**

23. _____ (Please initial) I agree to maintain a working phone number that can receive messages, which I am responsible for checking. I further agree to notify Pearl Medical Practice if or when my contact information changes.

24. _____ (Please initial) I understand that failure to adhere to these policies and/or failure to comply with provider's treatment plan is a violation of this agreement and could result in possible discharge from the practice.

25 _____ (Please initial) I attest that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half 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 asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, 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
Column Totals	_____	+ _____	+ _____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.