

Original Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates Revised: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**

Name:

(Last, First, M.I.)

M

F

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital

Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Previous or Referring Doctor:

Date of Last

Physical Exam: \_\_\_\_

## PERSONAL HEALTH HISTORY

Childhood Illness:  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

Immunizations  
and Dates:

Tetanus \_\_\_\_\_

Pneumonia \_\_\_\_\_

Hepatitis \_\_\_\_\_

Chickenpox \_\_\_\_\_

Influenza \_\_\_\_\_

MMR \_\_\_\_\_

*Measles, Mumps, Rubella*

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year

Reason

Hospital

Other Hospitalizations:

Year

Reason

Hospital

Have you ever had a blood transfusion? .....  Yes  No

Please turn to next page



**All questions contained in this questionnaire will be kept strictly confidential.**

**Sex:** Are you sexually active? .....  Yes  No  
If yes, are you trying for a pregnancy? .....  Yes  No  
If not trying for a pregnancy list contraceptive or barrier method used? \_\_\_\_\_  
Any discomfort with intercourse? .....  Yes  No  
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? .....  Yes  No

**Personal Safety:** Do you live alone? .....  Yes  No  
Do you have frequent falls? .....  Yes  No  
Do you have vision or hearing loss? .....  Yes  No  
Do you have an Advance Directive and/or Living Will? .....  Yes  No  
Would you like information on the preparation of these? .....  Yes  No  
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? .....  Yes  No

***Please remember that the following recommendations are very important to maintaining your health.***

**When in a car, wear your safety belt at all times.**

**While riding a motorcycle or bicycle, wear a helmet.**

**Always have functional smoke detectors and fire extinguishers in your home.**

**If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.**

**Keep the firearm and ammunition in separate locations.**

***FAMILY HEALTH HISTORY***

Any Family History of the Following Illnesses?

Hypertension (High Blood Pressure)	_____ yes _____ no	Who in family? _____
Heart Disease	_____ yes _____ no	Who in family? _____
Elevated Cholesterol	_____ yes _____ no	Who in family? _____
Diabetes	_____ yes _____ no	Who in family? _____
Stroke	_____ yes _____ no	Who in family? _____
Colon Cancer	_____ yes _____ no	Who in family? _____
Prostate Cancer	_____ yes _____ no	Who in family? _____
Ovarian Cancer	_____ yes _____ no	Who in family? _____
Skin Cancer	_____ yes _____ no	Who in family? _____
Mental Illness	_____ yes _____ no	Who in family? _____

### MENTAL HEALTH

- Is stress a major problem for you? .....  Yes  No
- Do you feel depressed? .....  Yes  No
- Do you panic when stressed? .....  Yes  No
- Do you have problems with eating or your appetite? .....  Yes  No
- Do you cry frequently? .....  Yes  No
- Have you ever attempted suicide? .....  Yes  No
- Have you ever seriously thought about hurting yourself? .....  Yes  No
- Do you have trouble sleeping? .....  Yes  No
- Have you ever been to a counselor? .....  Yes  No

### WOMEN ONLY

- Age at onset of menstruation: \_\_\_\_ Date of last menstruation: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Period every \_\_\_\_ days. Heavy periods, irregularity, spotting, pain or discharge? .....  Yes  No
  - Number of pregnancies \_\_\_\_ Number of live births \_\_\_\_
  - Are you pregnant or breastfeeding? .....  Yes  No
  - Have you had a D&C, hysterectomy or cesarean? .....  Yes  No
  - Any urinary tract, bladder or kidney infections within the last year? .....  Yes  No
  - Any blood in your urine? .....  Yes  No
  - Any problems with control of urination? .....  Yes  No
  - Any hot flashes or sweating at night? .....  Yes  No
  - Do you have menstrual tension, pain, bloating,  
irritability or other symptoms at or around time of period? .....  Yes  No
  - Experienced any recent breast tenderness, lumps or nipple discharge? .....  Yes  No
  - Date of last pap and rectal exam? \_\_\_\_/\_\_\_\_/\_\_\_\_

### MEN ONLY

- Do you usually get up to urinate during the night? .....  Yes  No If yes, # of times \_\_\_\_
- Do you feel pain or burning with urination? .....  Yes  No
- Any blood in your urine? .....  Yes  No
- Do you feel burning discharge from penis? .....  Yes  No
- Has the force of your urination decreased? .....  Yes  No
- Have you had any kidney, bladder or prostate infections within the last 12 months? .....  Yes  No
- Do you have any problems emptying your bladder completely? .....  Yes  No
- Any difficulty with erection or ejaculation? .....  Yes  No
- Any testicle pain or swelling? .....  Yes  No
- Date of last prostate and rectal exam? \_\_\_\_/\_\_\_\_/\_\_\_\_

### OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- Skin \_\_\_\_\_
- Head/Neck \_\_\_\_\_
- Ears \_\_\_\_\_
- Nose \_\_\_\_\_
- Throat \_\_\_\_\_
- Lungs \_\_\_\_\_
- Chest/Heart \_\_\_\_\_

- Back \_\_\_\_\_
- Intestinal \_\_\_\_\_
- Bladder \_\_\_\_\_
- Bowel \_\_\_\_\_
- Circulation \_\_\_\_\_
- Recent Changes In:**
- Weight \_\_\_\_\_

- Energy Level \_\_\_\_\_
- Ability to Sleep \_\_\_\_\_
- Other Pain/Discomfort:**
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Patient Rights

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

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Print Name

---

Signature

---

Date

Front Range Medical Arts  
5265 N. Academy Blvd. Ste 1800  
Colorado Springs, CO 80918  
(719) 599-0444

## ***PATIENT CONTACT CONSENT***

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

Guardian/Parent \_\_\_\_\_

**In caring for our patients, it may be necessary for your provider or a staff member to contact you by phone. When we are unable to speak to you directly, we like to leave messages when possible.**

**In order to protect your privacy, it is our policy to**

\*NOT leave messages with anyone except the patient or guardian

\*NOT leave specific information on answering machine/voicemail unless we have written permission to do so.

Please review the information below and consider carefully whom you wish to have access to your medical information, such as information about upcoming appointments, inquiries about your insurance or billing information. Please check the applicable ways for us to reach you/leave a message for you.

### **CONSENT**

\_\_\_ Home phone/answering machine/voice mail (detailed message)

\_\_\_ Office phone/voice mail (detailed message)

\_\_\_ Spouse (detailed message)

\_\_\_ Other \_\_\_\_\_

### **DENIAL**

I \_\_\_\_\_, wish to be contacted personally and do not authorize the office of Front Range Medical Arts to leave detailed messages with any other person or via answering machine/voice mail system.

I have the option to update and/or change my preferences of how you may contact me at any time by completing a new PATIENT CONTACT CONSENT FORM.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# FRONT RANGE MEDICAL ARTS

New Patient \_\_\_\_\_

Yearly Update \_\_\_\_\_

Change of Information \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: F \_\_\_\_  
M \_\_\_\_

\_\_\_\_\_  
Last Name First Name MI  
Social Security Number \_\_\_\_\_ Minor \_\_ or Single \_\_ Married \_\_ Divorced  
\_\_ Widowed \_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## INSURANCE INFORMATION

Self Pay \_\_\_\_\_ Insured \_\_\_\_\_

**\*Name of 1<sup>st</sup> Insurance Company** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Subscriber/ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Copay \$ \_\_\_\_\_

### **\*Guarantor information** (primary person insured)

Name \_\_\_\_\_  
Last Name First MI

Address \_\_\_\_\_  
(If different than patient's) street city state zip

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

**\*Name of 2<sup>nd</sup> Insurance CO** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Subscriber/ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Copay \_\_\_\_\_

**\*Name of Guarantor** (for 2<sup>nd</sup> insurance)

\_\_\_\_\_ MI  
Address \_\_\_\_\_ Last Name \_\_\_\_\_ City \_\_\_\_\_ First Name \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

\*I understand that I am responsible for my account, and if my insurance company fails to pay for my services I am responsible for any balances. **ATTENTION:** Some insurance companies require additional co-pays or deductibles for medical procedures (including joint injections and Osteopathic manipulation). We will bill your insurance company, and then bill you for any balances that are your responsibility. If you have questions, please call your insurance company.

**\*\*This office requires at least 24 hours notice to cancel an appointment.** If I fail to show up for my appointment, or fail to cancel 24 hours prior to my appointment time, **I will be responsible for a \$15 fee.**

**This consent will expire one year from the date signed below.**

\*\*\*I verify that the information I have provided is true and correct to the best of my knowledge. I authorize Front Range Medical Arts to apply for benefits to the insurance company(ies) listed above, for all services rendered, and assign payment directly to this office. I authorize the use of my signature on all insurance submissions. I authorize the release of any medical information necessary to process my claims. A copy of this authorization may be used in place of the original.

\_\_\_\_\_

Signature of Patient, Parent or Guardian

Today's Date

\_\_\_\_\_

Print name of Person Signing, if patient is a minor

Relationship to patient

Reviewed by