HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

Pharmacy Name_____ Phone_____

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

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

If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

Phone # Doctor we are Sending to _____

Concordia Physician Practice

Authorization For Release Of Health Information

Name of Patient: _____ Date of Birth: _____

I authorize _____ disclose my health information described below to:

- Person or Entity Concordia Physician Practice
- Street Address 112 Marwood Rd. #5000
- City, State, Zip Code Cabot, PA 16023
- Phone Number 724-352-4448 Fax- 724 352-4412

Purpose of request: Continuity of care

Timeframe of records to be released: 5 Yrs.

I request records be in (check one): ☑ paper form ☐ electronic form

I request to receive the records (check one): ☑ by certified mail ☐ pick up at office ☑ secure fax machine

What is your favorite number? _____ *(if requesting records in electronic form, the answer to this security question will be used for verification)*

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

✓ Physician progress notes	✓ Allergy list
✓ History & physical	_____ Interdisciplinary progress notes
✓ Consults	✓ Ancillary reports (lab, x-ray, etc.)
✓ Medication list	✓ Problem list
✓ Immunization record	_____ Billing statements

✓ Hospital documents (H&P, operative notes, discharge summary)

✓ Other (please specify) Include last Colonoscopy Mammo, EKG, Pneumovax, Zostavax, Tdap.

* The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV /AIDS related health information and/or records

_____ *Mental health information and/or records

_____ *Genetic testing information and/or records

_____ *Drug/alcohol diagnosis, treatment and/or referral information *(Federal regulations require a description of how much and what kind of information is to be disclosed.)*

_____ *Psychotherapy notes *(If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)*

I understand the following:

- I have the right to refuse to sign the authorization, if the authorization is requested by Concordia.
- Concordia will not condition treatment, payment, health plan enrollment, or health benefits eligibility upon the receipt of the individual's authorization with certain limited exceptions.
- I have the right to revoke this authorization by providing written revocation to the Office Supervisor except to the extent that information has been released in reliance upon this authorization.
- I have the right to inspect or copy any information to be used or disclosed under this authorization.
- The health information or records described above may be re-disclosed by the recipient, in which case it is no longer subject to the HIPAA Privacy Standards.
- There may be a charge to cover expenses such as labor for copying, time attributable to reviewing the request, locating the information, producing the copy, the cost of electronic media, and postage.

This authorization will expire within one year.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

For Internal Office Use Only:

_____ _____ ____Paper ____Electronic

Name of Person Releasing Medical Record Date Released Manner Released

Rev. 8/15