Health Information Exchange

Your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care, by allowing your providers to securely access your health records.

The following types of health information may be available:

- Hospital records
- Medical History
- Medications
- Allergies
- Lab Test Results
- Radiology Reports
- Clinic and healthcare provider visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

By signing below, I acknowledge I have received, read, and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE) OR that I have previously received this information and decline another copy.

____

Patient Name (Please Print) **Date of Birth**

____

Patient or Legal Guardian Signature **Today's Date**

MEDICAL HISTORY INTAKE FORM

Please complete all sections to assist us in providing you and your family with the best healthcare.

Last Name	First Name	MI	DOB

MEDICATIONS

List all medications you take, prescription and non-prescription and their dosage: ☐ **NO MEDICATIONS**

Medication	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

MEDICATION/FOOD ALLERGIES

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list: ___________________________ Reaction: ______________________________

Food	Reaction	Food	Reaction	Food	Reaction
☐ Chocolate		☐ Peanuts		☐ Strawberries	
☐ Corn		☐ Red Dye		☐ Wheat	
☐ Eggs		☐ Rice		☐ Other:	
☐ Iodine or Shellfish		☐ Soy		☐ Other:	

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

Condition	Date	Condition	Date	Condition	Date
☐ Alcohol Dependence	___/____/____	☐ Diabetes Type I	___/____/____	☐ Hepatitis	___/____/____
☐ Allergies	___/____/____	☐ Diabetes Type II	___/____/____	☐ Kidney Stones	___/____/____
☐ Anemia	___/____/____	☐ Diarrhea	___/____/____	☐ Other Kidney Disease	___/____/____
☐ Angina	___/____/____	☐ Disc Degeneration	___/____/____	___________________	
☐ Anxiety	___/____/____	☐ Duodenal Ulcer	___/____/____	☐ Liver Disease	___/____/____
☐ Arthritis	___/____/____	☐ Emphysema	___/____/____	☐ Low Blood Pressure	___/____/____
☐ Asthma	___/____/____	☐ Esophageal Reflux	___/____/____	☐ Migraines	___/____/____
☐ Blood Clots	___/____/____	☐ Gallbladder Stones	___/____/____	☐ Mixed Hyperlipidemia	___/____/____
☐ Broken Bones	___/____/____	☐ Goiter	___/____/____	☐ Obesity	___/____/____
☐ Cancer	___/____/____	☐ Gout	___/____/____	☐ Osteoarthritis	___/____/____
Type: _________________		☐ Headache	___/____/____	☐ Osteoporosis	___/____/____
☐ Chronic Blood Thinner Use	___/____/____	☐ Heart Attack	___/____/____	☐ Palpitations	___/____/____
☐ Chronic Bronchitis	___/____/____	☐ Heart Disease	___/____/____	☐ Rheumatoid Arthritis	___/____/____
☐ Chronic Fatigue Syndrome	___/____/____	☐ Other Heart Disease	___/____/____	☐ Sciatica	___/____/____
☐ Chronic Hepatitis	___/____/____	______________________	_____________	☐ Seizures/Epilepsy	___/____/____
☐ Chronic Kidney Disease	___/____/____	☐ Heart Failure	___/____/____	☐ Sleep Apnea	___/____/____
☐ Chronic Neck Pain	___/____/____	☐ Hepatitis	___/____/____	☐ Stomach Ulcer	___/____/____
☐ Chronic Sinusitis	___/____/____	☐ High Blood Pressure	___/____/____	☐ Stroke (CVA)	___/____/____
☐ Circulatory Disease	___/____/____	☐ High Cholesterol	___/____/____	☐ Thyroid Disease	___/____/____
☐ Colitis	___/____/____	☐ Irregular Heart Rhythm	___/____/____	☐ Tinnitus	___/____/____
☐ Congestive Heart Failure	___/____/____	☐ Hypertension	___/____/____	☐ Tuberculosis	___/____/____
☐ COPD	___/____/____	☐ Hyperthyroidism	___/____/____	☐ Other:_____________	___/____/____
☐ Crohn's Disease	___/____/____	☐ Insomnia	___/____/____	☐ COVID-19	___/____/____
☐ Depression	___/____/____	☐ Irritable Bowl Syndrome	___/____/____		

SURGICAL HISTORY

Procedure	Date	Procedure	Date	Procedure	Date
☐Angioplasty	___/____/____	☐Cholecystectomy	___/____/____	☐Liver Biopsy	___/____/____
☐Angioplasty w/stent	___/____/____	☐Colectomy	___/____/____	☐Open Reduction	___/____/____
☐Appendectomy	___/____/____	☐ Colostomy	___/____/____	Internal Fixation	___/____/____
☐Arthroscopy Knee	___/____/____	☐Gastric Bypass	___/____/____	☐Pacemaker	___/____/____
☐Back Surgery	___/____/____	☐Hernia Repair	___/____/____	☐Small Bowel Resection	___/____/____
☐Coronary Artery Bypass Graft	___/____/____	☐Hip Replacement	___/____/____	☐Thyroidectomy	___/____/____
☐Carpal Tunnel Release	___/____/____	☐Knee Replacement	___/____/____	☐Tonsillectomy	___/____/____
☐Cataract Extraction	___/____/____	☐LASIK	___/____/____		
☐Other: ______________	___/____/____				

Procedure	Date	Procedure	Date
☐Augmentation Mammoplasty	___/____/____	☐Masectomy	___/____/____
☐Bilateral Tubal Ligation	___/____/____	☐Myomectomy	___/____/____
☐Breast Biopsy	___/____/____	☐Reduction Mammoplasty	___/____/____
☐Cesarean Section	___/____/____	☐TAH/BSO (Total Abdominal Hysterectomy)/ (Bilateral Salpingo-Oophorectomy)	___/____/____
☐D and C (Dilation and Curettage)	___/____/____	☐Vaginal Hysterectomy	___/____/____
☐Hysterectomy	___/____/____		
☐Other:___________________	___/____/____		

FAMILY HISTORY

Please check if any family member has had any of the following conditions: ☐ **Adopted**

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
☐ ADD/ADHD						
☐ Alcoholism						
☐ Allergies						
☐ Alzheimer's Disease						
☐ Asthma						
☐ Blood Disease						
☐ Heart Disease						
☐ Heart Disease before age 50						
☐ Cancer						
Type:						
☐ Depression						
☐ Developmental Delay						
☐ Diabetes						
☐ Eczema						
☐ Hearing Deficiency						
☐ High Cholesterol						
☐ Hypertension						
☐ Inflammatory Bowel Disease						
☐ Kidney Disease						
☐ Learning Disability						
☐ Mental Illness						
☐ Migraines						
☐ Obesity						
☐ Osteoporosis						
☐ Peripheral Vascular Disease						
☐ Seizures/Epilepsy						
☐ Stroke (CVA)						
☐ Other:						
☐ Other:						

SOCIAL HISTORY

Do you use tobacco? □ Yes □ No □ Former Type of tobacco used? ___________________________________

Packs per day? ___________________________ Years smoked? ____________________ Year quit? _________________

Other Tobacco (cans, cigars, etc)? __________________________ Units per day? ___________ Years Used? ___________

Do you drink caffeine? □ Yes □ No Type? ________________ Amount Daily? ________________

Do you drink alcohol? □ Yes □ No □ Former Year Quit? __________________

Type? ____ How much per week? ___________________________________

Amount? ____ Last Drink? _____________________________________

Do you exercise regularly? □ Yes □ No If no, why? ____

What type of exercise? ____

Hand Dominance □ Left Handed □ Right Handed □ Both

Do you give permission to receive blood transfusion if medically necessary? __________________________

Do you have a preferred pharmacy? □ Yes □ No

Pharmacy: ____ Phone Number: _________________________________

Address: ____

Pharmacy: ____ Phone Number: _________________________________

Address: ____

Health Maintenance		**Date of Last**	**Disease Management**		**Date of Last**
Lipid Panel	□ Yes □ No	____/____/____	Abdominal Ultrasound	□ Yes □No	____/____/___
Stool cards/IFOBT	□ Yes □ No	____/____/____	Cardiac Stress Test	□ Yes □No	____/____/___
History and Physical	□ Yes □ No	____/____/____	Chest X-Ray	□ Yes □No	____/____/___
Colonoscopy	□ Yes □ No	____/____/____	Echocardiogram	□ Yes □No	____/____/___
Sigmoidoscopy	□ Yes □ No	____/____/____	EKG	□ Yes □No	____/____/___
Influenza Vaccine	□ Yes □ No	____/____/____	Eye Exam	□ Yes □No	____/____/___
Pneumococcal Vaccine	□ Yes □ No	____/____/____	Foot Exam	□ Yes □No	____/____/___
Tetanus Vaccine	□ Yes □ No	____/____/____	Pulmonary Function Tests	□ Yes □No	____/____/___
DEXA Scan	□ Yes □ No	____/____/____			
Gyn Exam	□ Yes □ No	____/____/____			
PAP	□ Yes □ No	____/____/____			
Mammogram	□ Yes □ No	____/____/___			
Breast Exam	□ Yes □ No	____/____/____			

Patient Signature Date Provider Signature Date

PRIVACY PRACTICES AND INSTRUCTIONS FOR DISCUSSING PERSONAL HEALTH INFORMATION

Patient Name: ____ Date of Birth: __________________

Preferred Phone Number: _____________________________________Today's Date: __________________

Emergency Contact: ____________________________ Phone Number: ______________________________

Notice of Privacy Practice and Patient Rights:

☐ I acknowledge receipt of Premier Medical Group's Notice of Privacy Practices and Patient Rights

I authorize the release of my personal health information to the following individuals:

Name: Relation to Patient:

____________________________________ ____

____________________________________ ____

The above mentioned individual is granted access to the below selected categories of my Electronic Health Record:

☐ ENTIRE Record ☐ All Test Results ☐ Appointments ☐ Medications ☐ Billing

☐ Other ____

I give Premier Medical Group permission to communicate messages regarding appointments, referrals, and test results as follows:

☐ You may leave messages on my voicemail

☐ You may leave messages with ____

☐ Other (please specify): ____

☐ I give permission for medical records to be mailed to my home if requested by phone or fax.

PATIENT PORTAL CARE MANAGER ACCESS

I authorize Premier Medical Group to grant *PATIENT PORTAL CARE MANAGER* access to:

____

The above mentioned individual is granted access to the below selected categories of my Electronic Health Record on the Patient Portal:

☐ Messages ☐ Appointments ☐ Documents ☐ IMH (Instant Medical Health Record)

☐ Financial Statements ☐ Medications ☐ Online Forms ☐ PHR (Public Health Record)

By signing I am allowing these methods of communication, any changes to this information will be made in writing to Premier Medical Group.

____

Patients Name (Please Print) **Patient or Legal Guardian Signature** **Date**