**Dr. Virginia Beaton, FNP – Family Health Practice**
**1262 E. Jericho Turnpike, Suite 1, Huntington NY 11743**
**Phone (631)549-2100    Fax (631)549-2109**

**Name:** ______________________________ **Date of Birth:** ____________________
**Address:** ______________________________ **Email:** ____________________
______________________________ **Phone:** ____________________
**Ethnicity:** ______________________________
**Emergency Contact:** ____________________ **Relation:** ____________________
**Phone Number:** ____________________

## Section I

**Note: This is a confidential record of your medical history and will be kept in this office. Information contained in this packet will not be released unless authorized to do so is received.**

What medical concerns bring you to our office? ______________________________
What is your home environment? **Live Alone  With Family  Single Parent  House  Apartment**
Marital Status: **S M D W**  Occupation: ______________________________
Disabled: **Y N**  Nature of Disability: ______________________________
Exercise Routinely: **Y N**  If YES, what & how often: ______________________________
History of Smoking: **Y N**  If YES, how many packs/how long: ______________________________
Advanced Directives/Living Will: **Y N**
Drink Caffeine: **Y N**

**Allergies:** Are you allergic to any medications? **Y N** If so, please list: ______________________________
**Medications:** Please list all medications you are taking regularly (including over the counter, herbal or natural.)

____________________ ____________________ ____________________
____________________ ____________________ ____________________

**Medical Illness or Conditions:** Please list any chronic conditions which you have been diagnosed to have.

____________________ ____________________ ____________________
____________________ ____________________ ____________________

**Operations**(Please list any surgeries and approximate year) **Hospitalizations**(Other than surgeries already listed)

| Year | Surgery | Year | Reason |
|---|---|---|---|
| ______ | ____________________ | ______ | ____________________ |
| ______ | ____________________ | ______ | ____________________ |
| ______ | ____________________ | ______ | ____________________ |
| ______ | ____________________ | ______ | ____________________ |
| ______ | ____________________ | ______ | ____________________ |

**Immunizations**(Check if YES and indicate year of last injection.)

❑ Influenza __________  ❑ Pneumonia __________  ❑ MMR __________
❑ Tetanus __________  ❑ Hepatitis A/B __________  ❑ Other __________

**Transfusions:** Have you ever had a blood transfusion? ❑ Yes ❑ No

**Weight:** What is your current weight? ______ One year ago? ______ Maximum? ______ When? ______

**Females Only:** Are you currently pregnant? ❑ Yes ❑ No
Are you currently nursing? ❑ Yes ❑ No
Date of last menstrual period? ______________

| Family Medical History | Age | Health (list significant illness) | Age at Death | If deceased, cause of death |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **Siblings** | | | | |
| | | | | |
| | | | | |
| **Spouse/Partner** | | | | |
| **Children** | | | | |
| | | | | |
| | | | | |

**Has any blood relative ever had?**(Check if yes and indicate relationship)

- ❑ Alzheimer's ________________
- ❑ Tuberculosis ________________
- ❑ Diabetes ________________
- ❑ Hypertension ________________
- ❑ Heart Disease ________________
- ❑ Alcoholism ________________
- ❑ Allergies ________________
- ❑ Heart attach before 55 ________________
- ❑ Bleeding Disease ________________
- ❑ Stroke ________________
- ❑ Seizures ________________
- ❑ Depression/Suicide ________________
- ❑ Mental Disorder ________________
- ❑ Cancer ________________

**If yes, which type(s):** ________________________
________________________

**Have you ever been diagnosed with?**(Check all that apply)

| | | | | |
|---|---|---|---|---|
| ❑ Cataracts | ❑ Angina | ❑ Ulcers | ❑ Anemia | ❑ Frequent Infection |
| ❑ Glaucoma | ❑ Heart Disease | ❑ Digestive Disorder | ❑ Bleeding Disorder | ❑ Cancer |
| ❑ Asthma | ❑ Heart Murmur | ❑ Hemorrhoids | ❑ Bone/Joint Disease | **Type:** _______________ |
| ❑ Allergies | ❑ Hypertension | ❑ Kidney Disease | ❑ German Measles | ❑ High Cholesterol |
| ❑ Stroke | ❑ Pneumonia | ❑ Kidney Stones | ❑ Rheumatic Fever | ❑ Enlarged Prostate |
| ❑ Seizures | ❑ TB/Lung Disease | ❑ Diabetes | ❑ Chicken Pox | ❑ Epilepsy |
| ❑ Pleurisy | ❑ Pre-Diabetes | ❑ Chicken Pox | ❑ Syphilis | ❑ Heart Attack |
| ❑ Jaundice | ❑ Liver Disease | ❑ Thyroid Disease | ❑ Depression | |

**Systems Review**(Please indicate those items that have been a recurrent or a recent significant change.)

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ❑ | ❑ | Good Health Lately | ❑ | ❑ | Recent Significant Weight Change |
| ❑ | ❑ | Unusual Fatigue/Weakness | ❑ | ❑ | Frequent Headaches |
| ❑ | ❑ | Weight gain | ❑ | ❑ | Cough or Phlegm |
| ❑ | ❑ | Weight loss | ❑ | ❑ | Coughing up blood |
| ❑ | ❑ | Fever or chills | ❑ | ❑ | Chronic bronchitis |
| ❑ | ❑ | Night sweats | ❑ | ❑ | Wheezing |
| ❑ | ❑ | Thyroid problems | ❑ | ❑ | Environmental/Occupational exposure to asbestos |
| ❑ | ❑ | Thirst or frequent urination | ❑ | ❑ | History of blood clots in legs or lungs |
| ❑ | ❑ | Eyeglasses or contact lenses | ❑ | ❑ | Loss of Appetite |
| ❑ | ❑ | Eye pain, vision problems | ❑ | ❑ | Nausea or Vomiting |
| ❑ | ❑ | Difficulty hearing | ❑ | ❑ | Abdominal Pain |
| ❑ | ❑ | Ringing in ears | ❑ | ❑ | Diarrhea, Constipation, Change in bowels. |
| ❑ | ❑ | Runny or stuffed nose | ❑ | ❑ | Yellow Jaundice or Liver Disease |
| ❑ | ❑ | Severe nose bleeds | ❑ | ❑ | Blood in stool |

| | | | | | |
|---|---|---|---|---|---|
| ❑ | ❑ | Hoarseness or voice change | ❑ | ❑ | Black/Tarry Stools |
| ❑ | ❑ | Sinus problem | ❑ | ❑ | Hemorrhoids |
| ❑ | ❑ | Chest pain | ❑ | ❑ | Stomach Ulcers |
| ❑ | ❑ | Palpitations (rapid heard beats) | ❑ | ❑ | Gallbladder Disease |
| ❑ | ❑ | Spells of unconsciousness | ❑ | ❑ | Anemia (low blood count) |
| ❑ | ❑ | Pain in legs while walking | ❑ | ❑ | Blood Transfusion |
| ❑ | ❑ | Swelling of the legs/ankles | ❑ | ❑ | Excessive bleeding |
| ❑ | ❑ | Shortness of breath (exertion) | ❑ | ❑ | Excessive bruising |
| ❑ | ❑ | Shortness of breath (lying) | ❑ | ❑ | Joint stiffness, pain, swelling |
| ❑ | ❑ | Painful urination | ❑ | ❑ | Previous mental illness |
| ❑ | ❑ | Frequent urination | ❑ | ❑ | Anxiety |
| ❑ | ❑ | Blood in urine | ❑ | ❑ | Depression |
| ❑ | ❑ | Kidney stones | ❑ | ❑ | Attempted Suicide |
| ❑ | ❑ | History of urinary tract infection | | | |
| ❑ | ❑ | Need to get out of bed to urinate? | | | |
| | | **How Frequently**: ____________ | | | |

**Women Only**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ❑ | ❑ | Vaginal Discharge/Infection | ❑ | ❑ | Painful Intercourse/Sexual Difficulty |
| ❑ | ❑ | Abnormal Vaginal Bleeding | ❑ | ❑ | Breast lump, pain or nipple discharge |

**Number of Pregnancies**(including miscarriages) ________

**Deliveries** ________ **Miscarriages** ________

**Method of Birth Control**: ______________________
(If Applicable)

**Date of last Period:** ______ / ______ / ________

**Date of last Pap Smear**: ______ / ______ / ________

**Date of last Mammogram**: ______ / ______ / ________

**Men Only**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ❑ | ❑ | Lump/Pain in Testicles | ❑ | ❑ | Problems with Erections |
| ❑ | ❑ | Decreased Sex Drive/Desire | ❑ | ❑ | Difficulty with Urine Stream |

---

## Section II

**Note: This section of the medical history contains questions that may be of a very personal and highly confidential aspect of your health. While we treat all information in your medical chart as confidential records, it can be released ONLY upon written consent from you for psychiatric, mental health, and substance abuse records.**

**The following sets of questions are to help us identify problem areas that may be difficult to discuss. Circle yes or no to each question and discuss any yes answers with your physician or nurse practitioner.**

### Alcohol / Drug Use

Do you drink alcohol? (If yes, please check the following) ❑ Yes ❑ No

| | | |
|---|---|---|
| ❑Rarely, Social (less than once/week) | ❑ Hard Liquor (1-3 oz.) daily | ❑ Hard Liquor (over 3 oz.) daily |
| ❑Beer (12 oz.) daily | ❑ Beer (2 bottles) daily | ❑Beer (3 bottles or more bottles) daily |
| ❑ Wine (1 glass) daily | ❑ Wine (2 glasses) daily | ❑ Wine (3 or more glasses) daily |

| | | |
|---|---|---|
| Do you use regularly or have you used in the past marijuana, Cocaine, heroin, speed, crack or other inhalants? | ❑ Yes | ❑ No |
| Have you felt that you NEED alcohol or other drugs? | ❑ Yes | ❑ No |
| Have you felt that you use too much alcohol or other drugs? | ❑ Yes | ❑ No |
| Have you tried to cut down or quit drinking alcohol or Your use of drugs? | ❑ Yes | ❑ No |
| Do you feel you have a drinking or a drug problem at this time? | ❑ Yes | ❑ No |

**Personal Safety**

| | | |
|---|---|---|
| Do you feel safe at home? | ❑ Yes | ❑ No |
| We all have arguments. When you and your partner and/or family Member argue, have you ever been physically hurt or threatened? | ❑ Yes | ❑ No |
| Do you feel your partner or family member controls (or tries to control) your behavior too much? | ❑ Yes | ❑ No |
| Does your partner or family member threaten you? | ❑ Yes | ❑ No |
| Have you ever felt forced to engage in unwanted sexual acts or Sexual contact with your partner or other family members? | ❑ Yes | ❑ No |

**Mental Health**

| | | |
|---|---|---|
| Have you ever been diagnosed to have depression? | ❑ Yes | ❑ No |
| Have you ever been diagnosed to have bipolar disorder, obsessive Compulsive disorder, or any other psychiatric condition? | ❑ Yes | ❑ No |

**HIV Exposure**

| | | |
|---|---|---|
| Have you ever been diagnosed to be HIV positive? | ❑ Yes | ❑ No |
| Do you have any concerns about possible exposure that you would Like to discuss or be treated for? | ❑ Yes | ❑ No |

**Comments:** ______________________________

______________________________

______________________________

**Patient Signature:** ______________________ **Date:** ________________

**Guardian Signature:** ______________________ **Date:** ________________
(If Applicable)

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

**What this is all about:** Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

**We have adopted the following policies:**

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but mustagree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by governmentagencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice andthe patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies toconform to your request.

**I**, ________________________ **date** ______ / ______ / __________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.