Coastal Medical
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Dear Patient:

The following questions are designed to collect important information about you and your health. Answering these questions before your office visit will allow more time for a detailed discussion with your provider. Please complete all questions.

PATIENT INFORMATION & PREFERENCES (*Please print or type*)

Last Name:_____First Name:_____M.I. _____

Preferred Name: _____ Date of Birth:_____/_____/_____

Primary Insurance: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Number: _____

YOUR MAJOR HEALTH CONCERNS OR QUESTIONS

What matters most to you about your health? _____

_____

_____

_____

_____

Describe briefly the major medical problem(s) or question(s) that you have: _____

_____

_____

_____

_____

List below all the medications that you take regularly or have taken regularly in the past month (including aspirin products, vitamins, birth control pills, etc.):

Drug	Drug Strength	How often you take the drug each day	Length of time you have taken the drug

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

Do you need medication refills today? ☐ Yes ☐ No If yes, please list below:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you having problems affording your medications? ☐ Yes ☐ No

Allergies: List any drug allergies (if any, briefly describe the reaction): _____

Are you allergic to antibiotics (such as penicillin or sulfa)? ☐ Yes ☐ No

Please answer the following questions regarding your Sexual Orientation and Gender Identity:

Birth Sex: ___ Male ___ Female ___ Unknown

What is your Gender Identity:

___ Male ___ Female

___ Female-to-Male (FTM) /Transgender Male/Trans Man ___ Male-to-Female (MTF) / Transgender Female/Trans Woman

___ Genderqueer, neither exclusively male nor female ___ Other: _____

___ Choose not to disclose

What is your Sexual Orientation:

___ Lesbian, gay, or homosexual ___ Straight or heterosexual ___ Bisexual

___ Do not know ___ Choose not to disclose ___ Other: _____

What is your current relationship status?

___ Single ___ Partner ___ Married

Please place a check mark next to the highest level of education you obtained in school:

____ Elementary ____ High School ____ College ____ Other: _____

How do you prefer to learn new information? (circle one)

Doing / Demonstration Reading / Written Materials Watching / Video or Presentations

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

PAST MEDICAL HISTORY

Place a check mark on the line next to the illness or illnesses that you currently have or have had in the past:

____ Anemia	____ Gallstones	____ Kidney stones
____ Arthritis	____ Glaucoma	____ Liver disease
____ Asthma	____ Gout	____ Nervous stomach
____ Cancer	____ Heart attack	____ Rheumatic fever
____ Cirrhosis	____ Heart trouble	____ Spastic colon
____ Depression or other mental illness	____ Hepatitis	____ Stomach ulcers
____ Diabetes	____ High blood pressure	____ Thyroid trouble
____ Emphysema	____ Kidney infections	____ Yellow jaundice

Serious past injuries (describe the type of injury and approximate dates of occurrences):

_____

_____

Previous surgery (Place a check mark on the short line next to the type of surgery you have had. On the long line, indicate the approximate date of surgery.):

____ Appendix_____	____Hemorrhoids _____
____ Breast surgery_____	____Hysterectomy _____
____ Eye surgery_____	____Open heart surgery _____
____ Gallbladder_____	____Stomach or colon surgery _____

____ Other surgery: _____

_____

Previous hospitalizations (other than surgery):

Hospital	Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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HEALTH MAINTENANCE

Vaccines

When was your last tetanus booster? _____

Have you had a flu (influenza) vaccine in the last 12 months? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

Have you had a pneumonia vaccine in the last 12 months? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

Have you ever had a shingles vaccine? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

Screenings

Do you have eye exams regularly? ☐ Yes ☐ No Where and when was your last eye exam? _____

Do you have dental exams regularly? ☐ Yes ☐ No Where and when was your last dental exam? _____

Have you ever had a colorectal cancer screening (colonoscopy)? ☐ Yes ☐ No
If yes, please tell us when and where, if known: _____

What is your usual weight? _____ What was your approximate weight one year ago? _____ What is your present weight? _____

WOMEN:

Name and address of your GYN Provider: _____

Have you had a "Pap" smear in the last two years? ☐ Yes ☐ No
Have you ever had a Mammogram? ☐ Yes ☐ No If yes, where and when was your last scan? _____
Have you ever used birth control pills? ☐ Yes ☐ No

Obstetrical History: Number of pregnancies: _____ Number of deliveries: _____

Please tell us about any other Specialists you see: List the name, location, and how often you see them:

_____

_____

_____

_____

_____

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Patient Name (Print): _____ Patient DOB: ____/_____/_____

FAMILY HISTORY

Is your mother living? ☐ Yes ☐ No (cause of death and age at death_____)
Is your father living? ☐ Yes ☐ No (cause of death and age at death_____)

Have any family members, either living or dead, ever had any of the following diseases? If yes, place a check mark on the short line next to the illness. On the long line next to the illness, put the name of the family member or the initial code letter of the family member that had the illness. The following code initials may be used:

Mother [M]	Brother [B]	Aunt [A]
Father [F]	Child [C]	Uncle [U]
Sister [S]	Grandparent [GP]	Cousin [CS]

(For example: If one of your grandparents and a cousin had tuberculosis: ✓ Tuberculosis GP, CS)

	Family Member		Family Member
____	Alcoholism _____	____	Heart Attack _____
____	Cancer _____		At what age(s)? _____
____	Breast cancer _____	____	High blood pressure _____
____	Colon cancer _____	____	Kidney disease _____
____	Ovarian cancer _____	____	Osteoporosis _____
____	Colitis _____	____	Tuberculosis _____
____	Diabetes _____	____	Other _____

SOCIAL HISTORY AND HABITS

Do you drink alcoholic beverages (wine, beer, liquor, etc.)? ☐ Yes ☐ No
If yes, how many alcoholic beverages do you have on average in a week? _____ per week

Do you smoke? ☐ Yes ☐ No

If no, have you ever smoked? ☐ Yes ☐ No

Please tell us how many years you have/had been a cigarette smoker: _____ year(s)

Have you ever tried to quit smoking? ☐ Yes ☐ No

How many days per week do you exercise for at least 20 minutes? _____ days per week

Are you sexually active? ☐ Yes ☐ No

What method of contraception do you use? ____Birth control pill ____Condom ____Diaphragm

____ Other:_____

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No

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ASSIGNMENT OF INSURANCE BENEFITS

Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Coastal Medical, I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY MY BENEFIT PLAN.

_____ _____/_____/_____

Patient's Signature — Date

Have you designated anyone to function as your legal guardian or decision maker (by completing a "living will" or "power of attorney" form) in the event that you are unable to make decisions regarding your health care?

☐ Yes ☐ No

If "YES," please write the name, address, phone number, and relationship of that individual:

Name:_____

Address: _____

Relationship to you: _____ Phone: _____

If "NO," please ask your physician about this.

I have reviewed the information in this questionnaire and verified that the information is accurate.

_____

Patient's Signature

If questionnaire was completed by someone other than the patient:

Relationship to patient: _____ _____

Patient's signature

PHYSICIAN'S NOTES:

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CONTACT INFORMATION FORM

Patient Name: _____ DOB: _____ /_____ /_____

Emergency Contact Information

Please complete all information below. In the event of an accident or other emergency, we will use this information to notify your preferred contacts:

Primary Contact Person:

Name: _____ DOB: _____ / _____ / _____

Relationship to patient: _____

Are they a Coastal Medical Patient: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Contact Person**:**

Name: _____ DOB: _____ / _____ / _____

Relationship to patient: _____

Are they a Coastal Medical Patient: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Permission to Discuss

I, the undersigned, hereby give Coastal Medical permission to discuss my medical information with:

Name #1: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name #2: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list any exclusions to discuss such as AIDS, HIV, psychiatric disorders, history of treatment for drug or alcohol abuse:

_____

_____

Patient/Legal Guardian Signature: _____

Date: _____ / _____ / _____

You may update this information at any time.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____ Email Address: _____

City: _____State: _____ Zip code: _____

Records to be released to: (Please complete in Full)

To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Records to be released from: (Please complete in Full)

From: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Delivery Method: Paper_____ Electronic: _____ (For Patient request)

*** Specific Dates of Service(s) Requesting** _____ To _____

☐ Progress/Consult notes ☐ Laboratory Reports ☐ X-Ray Reports

☐ Abstract Records (Progress notes/Tele visits, Lab reports, Xray reports, Special Studies)

For continuation of care, we provide last 2 years

☐ Complete Record (Last 10 years)

Reason for Request: _____

This authorization includes permission to transfer information regarding AIDS, HIV, Psychiatric disorders, and history of treatment for drug and alcohol abuse.

Have you seen a behavioral health specialist in our office?: ☐ Yes If yes, by whom?: _____ ☐ No

Do you authorize the release of these records as well?: ☐ Yes ☐ No

I understand that behavioral health diagnoses and medication are included in my medical records and will be included in this release of Medical Records Information.

I understand that I may revoke this authorization at any time prior to an actual release of records made in good faith that occurred in reliance on this authorization.

This Authorization will automatically expire in 120 days from the date signed below.

This Authorization does NOT allow an agency receiving records from further distributing them without additional written consent of the patient.

Signed: _____ **Date:** _____

If signed by Legal guardian or representative, please include the legal documents providing your authority.

* Requests for patient's medical records will be billed to the patient according to state regulations