PATIENT INFORMATION

Patient Name Today's Date

Social Security# Age Date of Birth

Mailing Address:

☐ Male ☐ Female Marital Status: S M W D Home Phone#

Work Phone # Mobile Phone#

Hobbies:

Employer: Occupation:

Email Address:

In case of Emergency Notify:

Relationship: Phone:

PAST MEDICAL HISTORY

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist not being aware of the general health and medical background of the patient. On occasion, such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

General Health ☐ Good ☐ Fair ☐ Poor

If not good please explain:

Do you exercise regularly? Y N If yes, please explain:

Height: Weight: Recent Weight Change? Y N

Date of last: Check Up: Chest X-ray: EKG:

Name of Primary Care Doctor:

Serious Illnesses:

Previous Surgery: **Name of Surgeon**: **Date of Surgery**:

Complications of Surgery?

Past Injuries:

FAMILY HISTORY

Tuberculosis Y N *Cancer* Y N *Diabetes* Y N

Heart Disease Y N *Lung Disease* Y N *Kidney Disease* Y N

Mental Conditions Y N *Epilepsy* Y N *Blood/Bleedings Disorders* Y N

High Blood Pressure Y N *Asthma* Y N

MEDICAL INFORMATION

Patient Name: ______________________________ Today's Date: ______________

Please list procedures being considered: ______________________________

____

Please list all medications which you are currently taking or have used in the past 6 MONTHS. Be sure to include any of the following:
Birth Control Pills, aspirin, ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications

List all medications currently taking or have taken in the last 6 months:

Name of Drug	Amount	Frequency

List all Drug Allergies: ______________________________

____

Have you ever used (circle) LSD / Speed / Cocaine / Marijuana? Never ______

Are you a smoker? YES/NO Ex-Smoker YES / NO Non-smoker YES / NO

How much were you smoking? ______________ Quit how long ago? ______________

What is your consumption of Coffee/Tea ______________ Tobacco ______ Alcohol ______

Please circle all of the following medical conditions you now have or have had in the past:
Bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / TB
Lung disease / asthma or wheezing / emphysema / bronchitis / irregular heart beat / stroke
Chest pain / heart disease / heart attack / heart burn / intestinal ulcers or bleeding / depression
Mental illness / drug or alcohol addiction / HIV / AIDS / Sleep Apnea / C-PAP /
Other:______________________ None of the Above______

Is there any possibility that you might be pregnant at this time? YES / NO

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fevers)? YES / NO

Patient Signature: ______________________________ **Date:** ______________

SUMMARY OF PRIVACY PRACTICES

This is a summary of our Notice of Privacy Practice, which describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted by law. It describes your rights to access and control of your Protected Health Information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time. We will use your protected health information as part of the rendering patient care, including treatment, payment, and healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or as required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of the disclosure indicated in the authorization.

You have the right to request a restriction of your protected health information. You have the right to request confidential communications of your protected health information. You have the right to inspect and copy your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to obtain a paper copy of this notice from us. 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 calling 205-879-6665 or by email at info@paulhowardmd.com. Please include "HIPAA Patient Complaint" on the subject line. We will not retaliate against you for filing a complaint. This summary was published along with the Notice of Privacy Practices.

I, _________________________, acknowledge I have received or had available to me a complete copy of the Notice of Privacy Practices for the office of Dr. Paul S. Howard. I hereby authorize Dr. Paul S. Howard to use and/or disclose my protected health information in any manner deemed necessary to provide optimal patient care.

____

Signature of Patient   Date