

130 9th Street N, Suite 120

Naples FL 34012

(239) 649-0550 ▪ fax (239) 649-1785

**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS**

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the release of any and all of my medical records (including any and all HIV/AIDS records, alcohol and/or substance abuse records, and psychiatric and/or psychotherapeutic records.)

**Information to be released to:**

**James M. Scanlon, M.D.**

**Russell W. Becker, D.O.**

**Naples Vascular Specialists**

**130 9th Street N, Suite 120**

**Naples FL 34102**

**Fax (239) 649-1785**

**Purpose of disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I request that copies of my medical record be made and mailed or delivered in a timely manner to the above address.

I do hereby agree to hold Naples Vascular Specialists, its agents and staff members free and harmless from any actions by it or them for alleged invasion of privacy, liable or slander, or defamation, arising in connection with the disclosures of such information.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

**Visit Date**: / /

**Name**: **DOB**: / /

**Gender:** **Race**:  **Prefer not to state**

**Ethnicity**:  **Non-Hispanic**  **Hispanic**

**Preferred Language**:

**Referring Provider**:

**Primary Care Provider**:

**Other Doctors/Providers**:

**Pharmacy Name:**

**Address:**

**Phone: Fax:**

**Reason for your visit today**:

**MEDICAL HISTORY-Please list all medical conditions/diagnoses.**

**SURGICAL HISTORY-Please list all prior surgeries/procedures (include date performed).**

**REVIEW OF SYSTEMS-Please check if you have any of the following.**

**General**

 Fevers  Chills  Night Sweats  Weight Loss  Fatigue/Malaise

**HEENT**

 Loss of hearing  Blurry vision/Loss of vision  Glaucoma  Retinopathy

 Nosebleeds  Hoarseness of voice  Difficult/painful swallowing

**Cardiovascular**

 Chest pain  Palpitations  Arrhythmias  Leg pain

 Leg discoloration, coolness or wounds  Swelling in legs  Varicose veins

 Pacemaker/Defibrillator  Previous heart surgery/catheterizations

**Pulmonary**

 Cough  Blood in cough/sputum  Shortness of breath  Wheezing

**Gastrointestinal**

 Abdominal pain  Nausea/Vomiting  Loss of appetite  Pain with eating

 Ulcers  Diarrhea  Constipation  Blood in stools  Jaundice

**Genitourinary**

 Blood in urine  Painful urination  Incontinence  Kidney stones

 Kidney disease  Prostate enlargement (BPH)  Impotence

**Neurological**

 Headaches  Dizziness  Fainting  Seizures  Weakness

 Numbness/tingling  Neuropathy  Dementia  Stroke or TIA

**Musculoskeletal**

 Joint pain or swelling  Arthritis  Muscle pain  Back pain

**Hematological/Immune/Lymphatic/Skin/Infectious disease**

 Anemia  Easy bleeding/bruising  Blood clots/DVT  Lymphedema  HIV  Hepatitis  MRSA infection  Cancer - Type:  Skin Rash  Slow to heal wounds

**SOCIAL HISTORY**

**Do you smoke?**  Never  Former  Current smoker

**Former smokers**:

What year did you quit? How many years did you smoke?

How many packs per day?

**Current smokers**:

How many years have you smoked? How many packs per day?

**Do you drink alcohol**?  Yes  No

How many drinks per day/week/month?

**Do you use illicit or recreational drugs**?  Yes  No Type?

**Do you do regular physical exercise?**   Yes  No

What type? Frequency?

**Marital status**:  Single  Married  Domestic Partner  Divorced  Widowed

**Do you work?**

 Yes Occupation:

 No  Retired / Former occupation:  Disabled

**Residency**:  I live here full-time  I live here seasonally, and also in:

**Do you have an advanced directive?**  Yes  No

**FAMILY HISTORY-Please list familial medical conditions (parents/siblings/children).**

**Family member** **Living/Deceased?/Age** **Medical conditions**

**ALLERGIES-Please list all medications/drugs you are allergic to.**

**Medication**  **Reaction**

**MEDICATIONS-Please list all medications and supplements that you are currently taking.**

**Medication name** **Dosage**  **Frequency**

**Patient Registration**

**Name**: **Date of Birth**: / /

**SSN:**

**Contact Information**

**Local/Primary Address**:

**City:** **State:** **Zip:**

**Alternate Address**:

**City:** **State:** **Zip:**

**Primary Phone #**:

**Mobile/Cell Phone #**:

**Alternate Phone #**:

**Email Address**:

**Primary Insurance**: **Insurance ID**:

**Insurance holder name and date of birth:**

**Secondary Insurance**: **Insurance ID**:

**Insurance holder name and date of birth:**

**Emergency Contact Information**

**Name**:

**Relationship to Patient**:

**Phone #**:

**Patient Signature**: **Date**: / /