# I Care Internal Medicine

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## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Name** *(Last, First, M.I.):* | | **DOB:** | | **Date:** | ☐ M | ☐ F |
| **Marital status:** | ☐ Single | ☐ Partnered | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed |

| **The reason(s) for today's visit:** |
|---|
| |
| |

| **List all medical conditions you are being treated for or have been diagnosed with:** |
|---|
| |
| |
| |
| |
| |
| |
| |

| **Please list the most recent date for the following: If you have never had the test/procedure please write N/A** | |
|---|---|
| Test: | Date: Please be as specific as possible |
| Colonoscopy | |
| Flu Shot | |
| Pap Smear- Females | |
| Mammogram-Females | |
| Bone Density | |
| PSA- Males | |

| **Surgeries: (You may use the back for additional surgeries)** ☐ **NONE** | |
|---|---|
| Surgery Type | Year |
| | |
| | |
| | |
| | |
| | |
| | |

NAME:_____ DOB:_____ Date:_____

| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:** ☐ **NONE** | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Allergies to medications:** ☐ **NO KNOWN ALLERGIES** | |
|---|---|
| Name the Drug | Reaction You Had |
| | |
| | |
| | |
| | |

| | | | | | |
|---|---|---|---|---|---|
| | Do you use tobacco? | | | ☐ Never | ☐ Yes |
| | ☐ Cigarettes ____ pks./day or week | ☐ Chew ____ /day or week | ☐ Pipe - ____#/day or week | ☐ Former- Year Quit _____ | |
| | ☐ # of years | ☐ Cigars #_____/Week | | | |
| | Do you currently use recreational or street drugs? | | | ☐ Yes | ☐ No |
| | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| | If yes, how often? ☐Rarely ☐Weekends ☐Occasionally ☐Moderate ☐Heavy ☐Recovering Alcoholic | | | | |
| | Do you have an Advance Directive or Living Will? | | | ☐ Yes | ☐ No |

| | **SIGNIFICANT HEALTH PROBLEMS** | | **SIGNIFICANT HEALTH PROBLEMS** |
|---|---|---|---|
| **Father** | | **Children** | |
| **Mother** | | | |
| **Sibling** | | | |
| | | | |
| | | **Grandmother** *Maternal* | |
| | | **Grandfather** *Maternal* | |
| | | **Grandmother** *Paternal* | |
| | | **Grandfather** *Paternal* | |

**MOHAMMAD JAMIL, P.C., dba I CARE INTERNAL MEDICINE**
**(623) 670-7772**

Effective Date of Notice: September 06, 2018

# PRIVACY NOTICE ACKNOWLEDGMENT AND COMMUNICATION CONSENT

Patient Name:_____ DOB: _____/_____/_____
*PLEASE PRINT NAME*

**Please list BELOW the pharmacy you use including cross streets or phone number:**

_____

**List Email Address BELOW for use with our secure patient portal: https://health.healow.com/icareim**

_____

☐ ***I do not have an email*** ☐ ***I do not wish to share my email or access my records via portal***

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

**Can we leave detailed or confidential messages on your voicemail?**
Yes ___ No ___ Home/Cell Phone Number:_____

**Can we mail test results to your home?**
Yes ___ No ___

**Can we lookup/import your prescription history electronically from your pharmacy?**
Yes ___ No ___

**Exclusions/Alerts** (Please note any information that you do not want released to authorized individuals:

_____

We must call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

NAME RELATIONSHIP PHONE NUMBER

1) _____

2) _____

***Must Sign Below for all information given:***
My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Mohammad Jamil, P.C., Notice of Privacy Practices.

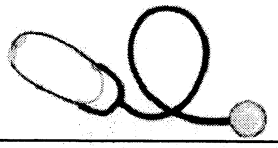
I also acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ _____
Patient Signature or Authorized Person to Sign DATE If not patient: Print name and relationship to patient (parent, legal guardian, personal representative, etc.)

***FOR OFFICE USE ONLY***
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

____ Individual Refused to Sign ____ Communication Barrier ____ Care Provided was Emergent
____ Other: _____ _____ ___/___/_____
Employee Name Date

Form 164.520-A



# I Care Internal Medicine

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## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name and Date of Birth: _____ Todays Date: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

(Use "x" to indicate your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| 1) Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| 2) Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |

**PLEASE ADD SCORE FOR QUESTIONS 1 & 2.** If total score is 3 or higher proceed to questions 3-9. If your score is 2 or less stop here.

| | | | | |
|---|---|---|---|---|
| 3) Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| 4) Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| 5) Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| 6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| 7) Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| 9) Thoughts that you would be better off dead or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

List any other providers and / or specialists you are currently seeing:

Providers first and last name or clinic name _____ Diagnosis /Specialty

- _____
- _____
- _____
- _____
- _____
- _____

Reviewed by: _____ Date: _____

Mohammad I. Jamil, M.D.

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## Please read and initial next to each policy:

1. ____ All narcotic medications will be prescribed by **appointment only** and at your providers discretion. Controlled medications being refilled require an appointment every 1-3 months and will be refilled at the discretion of Dr. Jamil or Dr. Ammunje.

2. ____ Medication refills- At your scheduled office visit, the provider will discuss appropriate monitoring intervals for your medications. Some medications are best monitored with laboratory testing in addition to an office visit. These include cholesterol lowering medication, blood pressure, diabetes medication, and thyroid supplements. Office visits are required every 1-4 months to monitor these conditions. Your doctor will advise you when to follow up. Please allow up to three business days for refill requests not made during your office appointment. We do not refill medications outside of our business hours.

3. ____No Shows or Cancellations - Please give us at least 24 hours' notice if you will not be able to make your scheduled appointment time. Excessive abuse of the policy will be subject to a **$25 fee** for each no show and your insurance will be notified.

4. ____ Payment - All CO-PAYS, DEDUCTIBLES and BALANCES OWED are due at the time of your appointment. Balances that remain unpaid after 90 days of the initial statement will be subject to being transferred to a collection agency and a 33% fee will be added to the amount owed. However, we do accept monthly payment plans and suggest initiating this so that your account is not sent to collections

5. ____ Forms for Attorneys, Disability, FMLA, etc. will be filled by **appointment only**. You must bring these forms with you at the time of visit. We do not currently charge for this service, however, we do require that you are prepared and have all information available for the physician. Please allow up to 7 business days for completion of these forms

**7.** ____ Inappropriate language, threats and/or behavior will not be tolerated, and, will be grounds for dismissal from practice.

8. ____ New Medications- We do not prescribe new medications without first evaluating a patient in office. This includes pain medications, antibiotics or other medications that have not already been prescribed by the physician.

9. ____ Please inform us of any changes to your health history, pregnancy, new medications including antibiotics or any new surgeries at each visit.

Thank you for your cooperation and understanding of our policies.

Signature:_____ DOB:_____ Date:_____