PINEWOOD MEDICAL CLINIC, P.A.

PATIENT INFORMATION

PATIENT'S NAME:________________________________ DOB:________ AGE:______ SEX:__________

SSN:______________________ RACE:__________________ ETHNICITY____________________________

PREFERRED LANGUAGE (CHECK ONE): ENGLISH___ SPANISH___OTHER___________ MARITAL STATUS _____

ADDRESS: CITY/ STATE/ ZIP ____

HOME #: _________________ CELL#_________________ EMAIL:____________________________

PHARMACY NAME:_______________________________ PHARMACY PHONE:_____________________

PRIMARY CARE PHYSICIAN: ____

ADDRESS__________________________________PHONE#:______________ FAX#__________________

EMERGENCY CONTACT NAME: ____

ADDRESS/CITY/STATE/ZIP:____

PHONE#:__________________ CELL PHONE #:__________________ RELATION:__________________

INSURANCE COMPANY NAME:____

ID#_______________________ GRP#______________________ PHONE #:_____________________

PRIMARY INSURED______________________________ DOB_____________ PHONE:________________

ADRRESS/CITY/STATE/ZIP:____

RELATION TO PATIENT (IF "SELF" LEAVE BLANK)____

____

Message Authorization

I give my written authorization to release pertinent information regarding date and time of appointments, lab results, diagnostic testing, referral information and/or screening services in the following way:

You may leave messages at my home: Y____ N____ You may leave messages on my cell phone Y___ N___

I DO NOT AUTHORIZE ANY MESSAGES TO BE LEFT: ____________________________ PLEASE SIGN

Signature of patient/responsible party:____

PINEWOOD MEDICAL CLINIC P.A. | POLICY REGISTRATION FORM

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Pinewood Medical Clinic P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge that I have had the opportunity to view the Notice of Privacy Practices.

X____ ____________

Signature of Patient/Guardian Date

AUTHORIZATION OF MEDICAL INFORMATION TO A SECOND PARTY

I give my written authorization to release pertinent information regarding date and time of upcoming appointments, labs, diagnostic testing, referral information, and/or screening services. You may release information to: (Name) ____

Relationship ______________________________ Telephone Number: ______________

X____ ____________

Signature of Patient/Guardian Date

PATIENT AUTHORIZATION

Notice of Privacy Practices Your name and signature below indicates that you have been offered a copy of Pinewood Medical Clinic P.A.'s Notice of Privacy Practices. Contact Pinewood Medical Clinic at 936-321-3110.

Name (please print): ______________________________

X________________________________ __________ Signature of Patient/Guardian Date

Assignment of Benefits, I authorize Pinewood Medical Clinic P.A. to submit to my insurance carrier Financial Authority to evaluate claims for payment. I understand that if my employer is responsible for paying all or part of this claim, they will receive the medical information necessary to pay for it, and I authorize release of this information. I further authorize payment of benefits, otherwise payable to me, to be made payable to Pinewood Medical Clinic P.A. I understand that I am financially responsible for all charges not covered by my insurance. If my insurance company is not in Pinewood Medical Clinic P.A.'s network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

X________________________________ __________ Signature of Patient/Guardian Date Consent for Medical I give permission to Pinewood Medical Clinic P.A. to perform the medical and Treatment surgical processes, treatment, and/or procedures that the clinician and other non-clinicians and assistants may deem necessary. In addition, I authorize Pinewood Medical Clinic P.A. to release any information obtained during the course of my examination and/or treatment to my healthcare insurer or other payer.

X________________________________ __________ Signature of Patient/Guardian Date

PINEWOOD MEDICAL CLINIC P.A./ REGISTRATION FORM

PATIENT CENTERED MEDICAL HOME PATIENT COMPACT

A Patient Centered Medical Home is a trusting partnership between a doctor led healthcare team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in the total healthcare program.

We trust you, our patient to:

- Tell us what you know about your health and illness
- Tell us about your need and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon, or let us know why you cannot so we can try to help and change the plan
- Tell us what medications you are taking and ask for refill at your office visit when you need one
- Let us know when you see other doctors and what medications they prescribe you on or change
- Ask other physicians/ specialists/ facilities to send us a report about your care when you see them
- Learn about your insurance so you know what it covers
- Keep your appointment as scheduled, or call and let us know you can't at least 24 hours in advance
- Pay your share of the visit fee at time of service
- Give us feedback so we can improve our service; our feedback box is at our checkout counter
- Visit our website at www.pinewoodmedicaltx.com and use the web portal to view lab results and and chart information

As we build your Medical Home, there may be changes in how we provide care. However, we will continue to:

- Provide you with your own doctor who knows you and your family whenever he/she is available
- Respect you as an individual, we will not make judgements based on race, religion, sex, or disability
- Respect your privacy, your medical information will not be shared with anyone unless you give us written permission or it is required by law
- Provider care given by a team of people led by your doctor
- Give the care you need when you need it
- Give the care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours, 7 days a week
- Take care of short illness, long-term disease and give advice to help you stay healthy
- Tell you about your health and illness in a way you can understand

Over the next several months, you may notice that:

- We ask what your health care goal is, or what you want to do to improve your health
- We use current best evidence in decision making about your care and offer support for self-management of your health and healthcare
- We ask you to help us plan your care and let us know if you think you can follow the plan
- We will give you a written copy of your care plan
- The team care members are doing more and/or different parts of the care
- We may ask you to have blood tests done before your visits so the doctor has the results at the time of your visit
- We may offer you a chance to join in a special type of doctor called a "group visit"
- We continue to increase the use of technology in the way we manage your healthcare in ways such as ePrescriptions, eMessaging, and online bill pay

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above, and we will acknowledge our agreement to you. Either you or your doctor may end this partnership at any time. If you choose to end the partnership, please notify us and tell us why. If your doctor decides to stop seeing you, we will notify you with an explanation as to why. With your written permission, we will forward a copy of your health records to your new physician.

Patient's Name: ______________________________ DOB: ______________

______________________ ______________________ ______________________

Patient Signature Date Physician Signature

HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hearby authorize use of disclosure of protected health information about me as described below. The following specific person or facility is authorized to make the requested use of disclosure:

REQUESTING RECORDS FROM:

Name of Dr. or Facility: ______________________

Address: ______________________

Phone No.: ____________ Fax No.: ____________

RELEASING RECORDS TO:

Name of Dr. or Facility: Pinewood Medical Clinic
6318 FM 1488 #100
Magnolia, TX 77354

Address: ______________________

Phone No.: ____________ Fax No.: 936-321-3125

Patient Name: ______________________ DOB: ____________

Records requested (please check one):

____ALL MEDICAL RECORDS	____DIAGNOSTIC STUDIES	OTHER: ____________
____EKG	____BLOODWORK/LABS	
____CONSULTATION NOTES	____IMMUNIZATION RECORDS	

DATES OF REQUESTED RECORDS: ______________________

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying the above mentioned facility in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on ____________ or one (1) year after the date of said authorization.

Signature of individual: ____________ Date: ____________ SSN or DOB: ____________

If applicable (for minors)
Signature of guardian: ____________ Date ____________ SSN or DOB: ____________

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This notice takes effect 1/1/2016, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this notice

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment We may use or disclose your health information to physician, dentist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation certification, licensing, or credentialing activities.

Your Authorization In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to **use** your health information or to disclose it to anyone for **any** purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification **of** (including identifying or locating) a family member your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions medical supplies, **x** rays or other similar forms of health information

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization

Required By Law: We may disclose your health information when we are required to do so by law

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others

National Security: We may disclose to military authorities **the** health information of Armed Forces personnel under certain circumstances We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address **at** the end of this **Notice.** If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19.00 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you Radiographs (x- rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities for the last 6 years but not before January 1st 2010. You can't request this accounting more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or may have questions or concerns please contact us

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice You
may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Privacy Officer
Steve Chin

(936)321-3110
6318 FM 1488, Suite 100
Magnolia, TX 77354

Patient Name: ____________________ DOB: ________

Pinewood Medical Clinic, P.A. | Dr. Chhay (Eric) Tay

Review of Systems

If you have any trouble with the following issues, check the problem(s) listed. If you do not have any of the problem selections, check the "No Problem" box.

General:
- ☐ Unusual weight changes
- ☐ Fever
- ☐ Fatigue
- ☐ Weakness
- ☐ Pain
- ☐ No Problem

Skin:
- ☐ Rashes
- ☐ Dryness
- ☐ Changes in skin, hair, or nails
- ☐ No Problem

Eyes:
- ☐ Pain
- ☐ Excessive tearing
- ☐ Dryness
- ☐ Redness
- ☐ Blurring vision
- ☐ Vision halos
- ☐ Vision flashes
- ☐ Eye strain
- ☐ No Problem

Ears:
- ☐ Discharge
- ☐ Earache
- ☐ Constant Ringing
- ☐ Hearing Loss
- ☐ No Problem

Nose:
- ☐ Nosebleeds
- ☐ Post nasal drip
- ☐ Discharge
- ☐ Sinus Pain
- ☐ No Problem

Mouth:
- ☐ Gum soreness
- ☐ Teeth condition
- ☐ Tongue pain
- ☐ No Problem

Throat:
- ☐ Hoarseness
- ☐ Swelling
- ☐ Trouble swallowing
- ☐ No Problem

Lungs:
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Phlegm/Sputum
- ☐ Pleurisy
- ☐ Asthma
- ☐ Snoring
- ☐ Apnea
- ☐ No Problem

Heart and Circulation:
- ☐ Chest pain, tightness, pressure
- ☐ Irregular heart beat
- ☐ Fast or slow heart beat
- ☐ Ankle swelling
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ No Problem

PATIENT NAME: ____________________ DOB: ________

PINEWOOD MEDICAL CLINIC, P.A. | DR. CHHAY (ERIC) TAY

URINARY:

- ☐ FREQUENCY OR PAINFUL URINATION
- ☐ PUS IN URINE
- ☐ LOSS OF CONTROL OF URINE/WETTING SELF
- ☐ URINATING AT NIGHT
- ☐ BLOOD IN URINE
- ☐ NO PROBLEM

STOMACH, INTESTINES, AND COLON:

- ☐ NAUSEA
- ☐ VOMITING
- ☐ VOMITING BLOOD
- ☐ CHANGE IN BOWEL HABITS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ FOOD INTOLERANCE
- ☐ RECTAL BLEEDING
- ☐ INDIGESTION
- ☐ FLATUS/PASSING GAS
- ☐ NO PROBLEM

MUSCLES, JOINTS, & BONES:

- ☐ JOINT STIFFNESS OR PAIN
- ☐ BACKACHE
- ☐ LIMITATION OF JOINT/MUSCLE MOVEMENT
- ☐ JOINT SWELLING OR REDNESS
- ☐ MUSCLE PAINS OR CRAMPS
- ☐ BONE PAIN
- ☐ NO PROBLEM

NERVOUS SYSTEM:

- ☐ FAINTING
- ☐ SEIZURES/EPILEPSY
- ☐ TREMORS
- ☐ MEMORY LOSS
- ☐ BLACKOUTS
- ☐ PARALYSIS
- ☐ TINGLING OF PART OF BODY
- ☐ HEADACHES
- ☐ NO PROBLEM

HORMONES:

- ☐ HEAD OR COLD TOLERANCE
- ☐ EXCESSIVE THIRST, HUNGER, OR URINATION
- ☐ NO PROBLEM

BLOOD / ALLERGIES:

- ☐ ANEMIA
- ☐ BLEEDING GUMS
- ☐ EASY BRUISING OR BLEEDING
- ☐ HIVES OR WELTS
- ☐ NO PROBLEM

PSYCHOLOGICAL:

- ☐ DEPRESSION
- ☐ LOSS OF INTEREST IN ACTIVITIES THAT ARE NORMALLY ENJOYED
- ☐ DIFFICULTY SLEEPING
- ☐ DIFFICULTY CONCENTRATING
- ☐ NERVOUSNESS
- ☐ ALCOHOL AND DRUG ABUSE
- ☐ NO PROBLEM

GENITALS:

MEN ONLY:

- ☐ SORES
- ☐ GROIN SWELLING
- ☐ PENILE DISCHARGE
- ☐ HERNIAS
- ☐ ~~TESTICULAR PAIN OR MASSES~~
- ☐ ERECTION DIFFICULTIES

WOMEN ONLY:

- ☐ IRREGULAR PERIODS
- ☐ VERY PAINFUL PERIODS
- ☐ BLEEDING BETWEEN PERIODS
- ☐ SORES
- ☐ VAGINAL DISCHARGE
- ☐ BREAST LUMP
- ☐ PAINFUL INTERCOURSE

PATIENT NAME: ______________________________ DOB: __________

PINEWOOD MEDICAL CLINIC, P.A.

NAME :	D.O.B / /
SEX ◯ Male ◯ Female	LAST PHYSICAL EXAM:

PAST MEDICAL HISTORY: PLEASE CHECK THE BOXES AND LIST THE YEAR OF ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE NOW OR HAVE BEEN DIAGNOSED WITH IN THE PAST:

- ○ AIDS/ HIV YR:
- ○ ABUSE YR:
- ○ ABNORMAL PAP SMEAR YR:
- ○ ALCOHOLISM/ DRUGS YR:
- ○ ANEMIA YR:
- ○ ANXIETY/ NERVES YR:
- ○ ALLERGIES YR:
- ○ ANOREXIA/ BULIMIA YR:
- ○ ARTHRITIS YR:
- ○ ASTHMA YR:
- ○ BLEEDING DISEASE YR:
- ○ BLOOD TRANSFUSION YR:
- ○ BLOOD CLOTS YR:
- ○ CANCER YR:
- ○ CHRONIC PAIN YR:
- ○ DEPRESSION YR:
- ○ DIABETES/SUGAR YR:
- ○ EMPHYSEMA YR:
- ○ EPILEPSY/ SEIZURES YR:
- ○ GALLBLADDER DISEASE YR:
- ○ GAS,INDIGESTION,REFLUX YR:
- ○ GLAUCOMA/ CATARACTS YR:
- ○ GOUT YR:
- ○ HEADACHE / MIGRAINES YR:
- ○ HEART DISEASE YR:
- ○ HEPATITIS A B C YR:
- ○ HIGH BLOOD PRESSURE YR:
- ○ HIGH CHOLESTEROL YR:
- ○ INTESTINAL DISEASE YR:
- ○ KIDNEY DISEASE YR:
- ○ LIVER DISEASE YR:
- ○ LUNG DISEASE YR:
- ○ MEASLES YR:
- ○ MONONUCLEOSIS YR:
- ○ MUMPS YR:
- ○ OSTEOPOROSIS YR:
- ○ PNEUMONIA YR:
- ○ PROSTATE PROBLEMS YR:
- ○ PSYCHIATRIC/MENTAL PROBLEMS
- ○ RHEUMATOID ARTHRITIS YR:
- ○ SERIOUS ACCIDENT/ INJURY YR:
- ○ SEXUALLY TRANSMITTED DISEASE YR:
- ○ STROKE YR:
- ○ TUBERCULOSIS YR:
- ○ ULCERS/ STOMACH YR:
- ○
- ○
- ○

OTHER:

____

____

PAST SURGICAL HISTORY: LIST THE YEAR YOU HAD ANY OF THE FOLLOWING.

○ NO SURGICAL HISTORY TO REPORT

SURGERY	YEAR	REASON

HOSPITALIZATIONS / MAJOR TRAUMA: LIST ANY HOSPITALIZATIONS.

○ NO HOSPITALIZATION HISTORY TO REPORT

HOSPITALIZATION	YEAR	REASON

PATIENT NAME: ________________________________ DOB: ____________

PINEWOOD MEDICAL CLINIC, P.A.

FAMILY HISTORY: PLEASE INDICATE THE AGE OF YOUR RELATIVES. CHECK IF ANY OF THE FOLLOWING CONDITIONS APPLY.

BLOOD RELATIVE	AGE	LIVING ?	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	MENTAL ILLNESS	CANCER SPECIFY TYPE	OTHER DISEASE
MOTHER		O	O	O	O	O	O		
FATHER		O	O	O	O	O	O		
SIBLINGS		O	O	O	O	O	O		
PATERNAL GRANDMA		O	O	O	O	O	O		
PATERNAL GRANDPA		O	O	O	O	O	O		
MATERNAL GRANDMA		O	O	O	O	O	O		
MATERNAL GRANDPA		O	O	O	O	O	O		
CHILDREN		O	O	O	O	O	O		

SIBLINGS: BROTHERS#:________ SISTERS#__________ ◯ HEALTHY?

CHILDREN: SONS#:__________ DAUGHTERS#_________ ◯ HEALTHY?

SOCIAL HABITS: HAVE YOU EVER USED ANY OF THE FOLLOWING?

HABIT	NEVER	NOW	QUIT	AMOUNT USED/ TYPE	# OF YEARS	YEAR STOPPED
TOBACCO	○	○	○	PACKS PER DAY:___________ ◯ CIGARS ◯ CIGARETTES ◯ PIPE ◯ SMOKELESS ARE YOU INTERESTED IN QUITTING? ◯ YES ◯ NO		
ALCOHOL	○	○	○	DRINKS PER WEEK OF: ◯BEER_____ ◯ WINE____ ◯ LIQUOR_____		
STREET DRUGS	○	○	○	TYPE______________ ◯ POT ◯COCAINE ◯ PAIN PILLS ◯ IV◯ OTHER		
EXERCISE	○	○	○	HOURS OR SESSION PER WEEK:_____________ TYPE_______________________________		
CAFFEINE	○	○	○	SERVINGS PER DAY OF: ◯ENERGY DRINKS _____ ◯COFFEE___ ◯ TEA_____ ◯ SODA_____		

NUTRITIONAL ASSESSMENT: DO YOU FOLLOW A SPECIAL DIET OR HAVE ANY DIETARY RESTRICTIONS?

◯ NO

◯ YES, PLEASE SPECIFY ________________________________

ARE YOU SEXUALLY ACTIVE?

NUMBER OF SEXUALLY PARTNER IN THE PAST 12 MONTHS ________

DO YOU EXERCISE SAFE SEX PRECAUTION? ◯ YES ◯ NO

WOULD YOU LIKE INFORMATION REGARDING PRECAUTIONS? ◯ YES ◯ NO

DO YOU HAVE AN ADVANCE DIRECTIVE? ◯ YES ◯ NO **IF NO, WOULD LIKE ONE?** ◯ YES ◯ NO

PATIENT NAME: ______________________________ DOB: __________

PINEWOOD MEDICAL CLINIC, P.A.

PREVENTATIVE CARE: PLEASE WRITE THE YEAR IF YOU HAVE RECEIVED THE FOLLOWING ITEMS

IMMUNIZATIONS	YEAR		
HEP A			
HEP B			
ZOSTAVAX (SHINGLES)			
PREVNAR (PNEUMONIA)			
TETANUS			
HAVE YOU HAD FLU SHOT SINCE THE MOST RECENT SEPTEMBER 1ST? ◯ES ◯O			
SCREENING EXAMS	**YEAR**	**PHYSICIAN**	
CHOLESTEROL / LIPID SCREENING			
STOOL FOR OCCULT BLOOD TEST			
COLONOSCOPY (>AGE 50)			

DIABETIC EYE EXAM (DIABETIC PATIENT) YEAR: _____ FINDINGS: ◯NORMAL ◯RETINOPATHY ◯MACULAR EDEMA

FACILITY OR NAME OF OPTHAMOLOGIST: ______________________________

MALE PATIENTS (ONLY)	YEAR	RESULTS	PERFORMED BY :
PROSTATE EXAM			
PSA (BLOOD TEST)			
DO YOU PERFORM A MONTHLY TESTICULAR SELF EXAM? ◯ YES NO			

FEMALE PATIENTS (ONLY)	YEAR	RESULTS	PERFORMED BY:
MAMMOGRAM (> AGE40)			
DEXA/ BONE DENSITY (>AGE 50)			
PAP SMEAR			

DO YOU PERFORM A MONTHLY BREAST EXAM? ◯YES ◯NO

MENSTRUAL HISTORY: AGE AT FIRST MENSES: _______ REGULAR ◯ IRREGULAR ◯PAIN/ CRAMPS

PREGNANCY TOTAL #: _______ VAGINAL DELIVERIES#: __________ C-SECTIONS #: __________

MISCARRIAGES#: _______ ABORTIONS#: _______ COMPLICATIONS: ______________________

COORDINATED CARE: PLEASE LIST ANY OTHER SPECIALISTS YOU MAY SEE AND WHY

PHYSICIAN NAME	SPECIALTY	REASON

COPING / STRESS TOLERANCE ASSESSMENT

WHO LIVES WITH YOU? ◯ALONE ◯SPOUSE ◯CHILDREN ◯PARENT(S) ◯OTHER: ______________

CURRENT STRESSORS◯ FAMILY◯ FRIENDS◯ JOB◯ MARRIAGE◯ MONEY◯ OTHER: ______________

IN THE PAST YEAR HAVE YOU HAD A MAJOR LOSS OR CHANGE IN YOUR LIFE? ◯NO ◯YES ______________

PATIENT SIGNATURE: ______________________________ **DATE** ______________

PATIENT NAME: ______________________________ DOB: ____________

PINEWOOD MEDICAL CLINIC, P.A.

PATIENT MEDICATION HISTORY

PRESCRIPTION MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY	PURPOSE

OVER THE COUNTER (OTC) MEDICATIONS:

DRUG NAME	STRENGTH	FREQUENCY	PURPOSE

SUPPLEMENTS / HERBALS:

SUPPLEMENT NAME	STRENGTH	FREQUENCY	PURPOSE

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ◯ NO ◯ YES, LIST BELOW:

X______________________________ DATE: ____________________

PATIENT SIGNATURE

REVIEWED BY: ______________________