Prescription 2 Fitness

Health History

Date_______________ Chart Number_________

Name__________________________________ Date of Birth__________

Address____

____

Social Security Number ____

Marital Status ___________________ Spouse Name ______________________

Children (Names and Ages) ____

____

Occupation ____

Phone (Home) _____________ Work_____________ Cell___________________

Emergency Contact Name __________________________ Number __________

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Please circle medication allergies or intolerance:

None	Aspirin	Other (please list)
Penicillin	Codeine	______________
Sulfa	Hydrocodone	______________
Keflex	Steroids	______________
Tetracycline	Novacain	______________
Doxycycline	Morphine	______________
Erythromycin	Demerol	______________
Cipro	Phenergan	______________
IV Dye	Arthritis Meds	______________

Please circle previous surgical procedures:

Appendectomy	Sinus Surgery
Tonsillectomy	Gastric Bypass
Heart Bypass	Hernia Repair
Coronary Angioplasty (Stent Placement)	Knee Surgery (Right, Left)
Pacemaker Placement	Knee Replacement (Right, Left)
Gallbladder (Open, Laproscopy)	Shoulder Surgery (Right, Left)
Mastectomy (Right, Left)	Prostate Resection
Hysterectomy (Total, Partial)	Lumbar Spine Surgery
Tubal Ligation	Cervical Spine Surgery
Vasectomy	Hip Replacement (Right, Left)
Hemorrhoidectomy	Carpal Tunnel (Right, Left)
Cancer Surgery (details below)	

Others ____
____
____

Please circle all chronic illnesses or problems:

High Blood Pressure	COPD	Degenerative Disk Disease
Diabetes	Emphysema	Osteoporosis
Seizures	Stroke	Arthritis
High Cholesterol	Migraine	Back/Neck Pain
Heart Disease	Headaches	Depression
Heart Rhythm Disorder	Allergic Rhinitis	Anxiety
Mitral Valve Prolapse	Sinusitis	Dementia
Congestive Heart Failure	Thyroid Disorder	Cancer (type______)

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Please list current medications and directions:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Please list chronic illnesses of immediate family members (this includes hypertension, diabetes, heart disease, cancer, stroke, etc.)

Father ____________ Brother1 ____________ Sister1 _____________

Mother ____________ Brother2 ____________ Sister2 _____________

Do you drink alcohol? No ____ Rarely _____Occasionally ____ Frequently ____

Are you a smoker? Yes ____ No ____ Packs per day? _____________________

Previously smoked? Yes ____ No ____ Year that you quit smoking? __________

Previous Physician: ____

Referred by: ____

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Privacy Act

Your Rights
The following is a statement of you protected health information.
You have the right to inspect and copy protected health information.
Under federal law, however, you may not inspect or copy the following records; Psychotherapy notes, information compiled in a feasible anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your health information.
This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operation. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Health Professional.
You have the right to request and receive confidential communication from us by alternative means at an alternative location. You have the right to obtain a paper copy of this notice from us and if you have agreed to accept this notice alternatively, i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we may have made, if any, to your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Resources if you believe your privacy rights were violated. You may also file a complaint by notifying our privacy contact of your complaint. We will not retaliate against you if you file a complaint.
This notice was published and becomes effective 4/14/03.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.

Signature below is our only acknowledgement that you have received this Notice of Privacy Practices.

Print Name _______________ Signature ________________ Date_______

Ok to leave message/text results on answering machine or with persons listed below?
Yes _____ No _____

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Please list the names of any individual that we can contact or release information regarding your medical information. Please include all telephone numbers and/or cell phone numbers.

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