THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

ADULT PATIENT HISTORY

Date: _____

Please complete both sides of this form.

If today's appointment is a Medicare Annual Wellness visit or a Complete Physical, we will review your preventative health needs. Should you need care for a new or ongoing medical problem, it could be addressed today, but a co-pay will be required. We may need to schedule a separate appointment.

PATIENT NAME: _____ Prefer to be called / Nickname _____

Date of Birth: _____

Gender per your health insurance
☐ Male
☐ Female

If different from above, what is your current gender identity?
☐ Trans male/Trans man
☐ Trans female/Trans woman
☐ Genderqueer/Gender non-conforming
☐ Different identity – please state: _____

Do you have a Living Will, Health Care Power of Attorney or an Advance Care Directive? ☐ Yes ☐ No
Ask our staff if you would like Advance Care Directives information

What type of diet do you follow? _____

Do you use tobacco or other cigarettes?
☐ No, never ☐ Yes, packs/day age started
☐ Previously smoked ____ packs/day, for____ years, stopped in_____(year)
☐ Oral tobacco user ☐ e-cigarette / vapor cigarette user

Do you drink alcohol?
Please check the item that best describes your current consumption of alcohol:
☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times per week
☐ Previous heavy alcohol use. If stopped completely – month/year: _____
If you drink alcohol, how much do you consume on a typical day when you are drinking:
☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 to 9 drinks ☐ 10 or more drinks

Do you currently use street drugs (such as marijuana, cocaine, heroin, opioids or others)? ☐ Yes ☐ No

Have you ever used IV street drugs? ☐ Yes ☐ No

What is your current exercise routine? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic partner

Who lives with you? _____

What is your occupation and where do you work? _____

Are you under any unusual stressors? ☐ Work ☐ Family ☐ Financial ☐ Illness ☐ Other

Do you use any home medical equipment? ☐ Yes ☐ No
If yes, what medical equipment and who is your supplier: _____
What form of birth control, if needed, do you use? Number of pregnancies: _____
Sexual History: ☐ Currently sexually active ☐ With men ☐ With women ☐ With men and women
☐ Never ☐ Not active in past 12 months ☐ More than 3 partners in lifetime

CURRENT HEALTH CONCERNS (please list):

_____

_____

Please complete both sides of this form.

ADULT PATIENT HISTORY *page 2*

IMMUNIZATIONS & HEALTH MAINTENANCE (give date of last shot/exam)

☐ Tetanus shot with or without Whooping Cough_____ ☐ Flu shot_____ ☐ Cholesterol test _____

☐ Pneumonia shot - Prevnar 13 or Pneumovax (if over 65) ☐ Shingles shot (if over 50)

Colon Cancer Screening (if over 50) ☐ Stool Test_____ ☐ Colonoscopy_____ ☐ Sigmoidoscopy _____

☐ If smoking history, last lung cancer screening / CT scan (if 55 to 80) _____

Women only: (please give date of last exam)

☐ Mammogram_____ ☐ Last Period_____ ☐ PAP Smear_____ ☐ Bone Density _____

Men only: (Please give date of last exam) ☐ PSA test _____

Allergies to medications and the reaction you had: _____

New Patients: list all medications. **Current patients:** list any new medications. (Include non-prescription.)
Please ask for a second sheet if needed

Medication	Dose	How often

Medical history (Any illness for which you have received a diagnosis):

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Back Problems ☐ Chronic Pain ☐ COPD / Emphysema ☐ Depression

☐ Diabetes ☐ Fibromyalgia ☐ Reflux / Heartburn ☐ High Cholesterol ☐ Heart Disease/Stroke

☐ High Blood Pressure ☐ History of Cancer Type(s)_____ ☐ Kidney Disease ☐ Thyroid Disorder

Other:_____

List previous surgeries: _____

Family History of Major Medical Problems (if deceased, list cause and age of death)

Father:_____

Mother:_____

Brothers/Sisters:_____

Circle any of the following symptoms you currently experience

General	Appetite changes, chills, fatigue, fever, night sweats, weight gain, weight loss
Skin	Changes in wart/mole, new lesions, rash
HEENT	Eye exams by ophthalmologist or optometrist, glasses or contact lenses, headache, head injury, hearing loss, hoarseness, disturbances
Neck	Neck mass, neck pain
Respiratory	Shortness of breath, cough, coughing with blood, snoring
Breast	Breast mass, breast pain, nipple discharge
Cardiovascular	Chest pain, difficulty breathing lying down, difficulty breathing on exertion
Gastrointestinal	Abdominal pain, black stool, tarry stool, bloody stool, constipation, diarrhea, difficulty swallowing, indigestion, nausea
Female Genito-urinary	Blood in urine, change in bladder habits, painful urination, hot flashes, menstrual irregularities, painful menstruation, are you in Menopause Yes___No _____
Male Genito-urinary	Blood in urine, change in bladder habits, painful urination, sexual difficulty, discharge from penis, urine leakage
Musculoskeletal	Back pain, joint pain, muscle weakness, swelling of extremities
Neurological	Dizziness, falls, loss of consciousness, stroke-like symptoms, seizures, falling, trouble walking
Psychiatric	Change in sleep pattern, depression, insomnia, mood changes, nervousness
Endocrine	Heat or cold sensitivity, excessive thirst, hunger or urination
Hematology	Easy bruising, easy bleeding, enlarged lymph nodes

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Compound Authorization for Release of Information

Date: _____ MRN: _____

PATIENT NAME: _____ **Date of Birth:** _____

Prefer to be called / Nickname _____

By signing this form, you authorize The Family Health Centers to release protected health information for the above named patient according to the instructions below.

Voicemail/Answering Machine

The Family Health Centers is authorized to leave appointment information and/or test results on your voicemail/answering machine.

☐ No ☐ Yes

_____

(Please verify your phone number)

Email Address

The Family Health Centers is authorized to send secure, HIPAA-compliant emails related to our Patient Portal, personal health information, practice hours and practice announcements.

☐ No ☐ Yes

Email address: _____

(Please verify your email address)

List below any individuals who may have access and can speak on your behalf about your health information, make/cancel appointments, pick-up prescriptions, and/or be designated as your emergency contact.

_____
Name / Relationship

_____
Phone

☐ Emergency Contact
☐ Family/Billing/Financial Information
☐ Medical Information
☐ Any/All Information

_____
Name / Relationship

_____
Phone

☐ Emergency Contact
☐ Family/Billing/Financial Information
☐ Medical Information
☐ Any/All Information

_____
Name / Relationship

_____
Phone

☐ Emergency Contact
☐ Family/Billing/Financial Information
☐ Medical Information
☐ Any/All Information

Rights of the Patient

I understand that:

- I have the right to revoke this authorization at any time.
- I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to The Family Health Centers.
- A revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature Date

Description of patient representative's authority, if applicable: _____

_____

_____

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

Notice of Patient Privacy Practices
Uses and Disclosures of Health Information

We, (The Family Health Centers of Asheville, Arden and Hominy Valley), are required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow these guidelines.

Your health record is the physical property of The Family Health Centers; however, the information in the health record belongs to you.

We may use your personal health information for treatment, payments, and operations; for example, administrative purposes and evaluation of the quality of care we provide. You may request that we do not use or disclose this information to a particular entity or person, however, we ask that such a request be made in writing by you.

Although your request will be considered, please be aware we may not be able to grant your request under certain instances required by law. We review all such requests on an individual basis to determine our ability to grant them and we will respond to your request within thirty (30) days, if possible.

Understanding Health Information
A record is made of each visit you make to our practice. This typically contains your history, examinations, symptoms, diagnoses, test results, and plans of care or treatment. This information is referred to as your medical record and may serve as the following:

- *Basis for planning your care and treatment*
- *Means of communication with other health professionals who care for you, your child or dependents*
- *Legal document describing the care received*
- *Means by which you or third-party payers may verify services rendered and for payment purposes*
- *Tools for educating health professionals*
- *Sources of data for medical research*
- *Sources of information for public health officials*

We will not use or disclose your health information without your authorization except as described in this notice.

You may request to inspect or obtain a copy of your health information or that of your children or dependents. We may charge a reasonable fee for copies. We attempt to provide this information with thirty (30) days of your request.

If you believe any information in your record is incorrect or if important information is missing, you may request we amend or add such information. These requests must be in writing on a release form that we provide.

You may request a written accounting of all disclosures made of your Protected Health Information. This request may be made for all information we have after April 14, 2003. We will keep an accounting of disclosures made OTHER THAN those for treatment, payment or other healthcare operations as defined in this notice for six (6) years. We will respond to your request within thirty (30) days, if possible. If more than one request is made within a 12 month period, you may be charged a reasonable fee.

Use of your contact information

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purposes of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare-related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages to be left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

We must obtain a written authorization from you to disclose information for purposes other than outlined in this brochure. You have the right to revoke this authorization, except to the extent we have already used or disclosed this information.

You have the right to obtain and keep a written copy of this notice.

Concerns and Complaints

If you believe your privacy rights may have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services (DHHS). All such concerns or complaints must be submitted in writing. You will not be penalized for filing a complaint. To file a complaint or concern with our practice, contact our Privacy Officer:

Terry A. McLane MBA, CEO HIPAA COMPLIANCE OFFICER
The Family Health Centers of Asheville, Arden & Hominy Valley, PA
Email: privacy@thefhc.net
Telephone: (828) 258-8681

Changes to this Policy

The Family Health Centers reserves the right to amend, change or update this policy at any time. When this occurs, a new “Notice of Patient Privacy Practices” will be posted on The Family Health Centers website, fhconline.com, and will be available at your next appointment or upon request.

Updated July, 2018

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ACKNOWLEDGEMENT OF RECEIPT OF PRACTICE NOTICES

My signature below acknowledges and authorizes that I understand, agree and have been informed of my rights in regard to my Protected Health Information (HIPAA – Health Insurance Portability and Accountability Act). I have received the Notice of Privacy Practices, and have been given the opportunity to ask questions about this notice, and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of my communications between the Practice and myself or others.

CONSENT OF CARE AGREEMENT

The Family Health Centers may render treatment to me and provide information to other caregivers concerning my condition while under medical care.

COMMUNITY EXCHANGE AGREEMENT

Release of medical records to another physician involved in my care or to the insurance company for payment of claims is approved.

ACQUIRE MEDICATION HISTORY AGREEMENT

The Family Health Centers may acquire a medication history from my pharmacy or insurance company.

ACQUIRE MEDICAL RECORDS AGREEMENT:

The Family Health Centers may acquire medical records from any provider I have seen in order to assist in my treatment while under medical care at any of their facilities.

Print Patient Name _____ Date of Birth _____

Patient Signature (or Representative Signature) _____ Date _____

Print Name of Person Signed Above (if other than patient) _____

OFFICE USE

MR # _____ DATE FAXED /INITIALS _____