

NEW PATIENT HEALTH HISTORY FORM

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

| | | | | |
|---|--|-----------------------------|----------------------------|------|
| Name (Last, First, M.I.): | | <input type="checkbox"/> M | <input type="checkbox"/> F | DOB: |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | | |
| Contact: iPhone | | | | |
| Address | | | | |
| Email | | | | |
| Previous or referring doctor: | | Date of last physical exam: | | |

Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, the physicians of One to One Health originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations, such as assessing quality and reviewing competence of healthcare professionals.

One to One Health Notice of Privacy Practices provides specific information and complete description of how my personal information may be used and disclosed. I understand that a copy of the Notice of Privacy Practices is available at the front desk and understand that I have the right to review the notice prior to signing this consent. I understand that One to One Health reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that One to One Health is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that One to

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NOTE: One to One Health must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want One to One Health to have access to disclose your Private Health Information to your spouse or any other person during your treatment, please sign below.

Patient Signatures

20

PERSONAL HEALTH HISTORY

| | |
|-----------------------------------|---|
| Childhood Illnesses: | <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio |
| Immunizations and Disease: | <input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Chickenpox <input type="checkbox"/> Influenza <input type="checkbox"/> MMR: Measles, Mumps, Rubella |

List any medical problems that other doctors have diagnosed.

Symptoms

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |
| | | |

Health History Example

Barnes

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Advanced Health Assessment and Diagnostic Reasoning Jacqueline Rhoads, 2006 What ingredients go into a thorough health history and physical examination How do effective interviewing skills thorough assessment sound clinical reasoning and accurate documentation work together to refine our diagnostic choices These are the kinds of questions you'll explore and answer inside this resource Written by a noted nurse educator this accessible text guides you through the essentials of conducting a clinically relevant assessment and applies these principles to the diagnosis of specific commonly encountered disorders

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