UVALDE MEDICAL & SURGICAL ASSOCIATES

Provider Approval:_____
Financial Admin Approval: _____
Appointment Date/Time: _____

HEALTH HISTORY QUESTIONNAIRE

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

Name/Nombre:			☐ M ☐ F		**DOB/FDN:**	
Marital status/Estado Civil:	☐ Single/Soltero/a ☐ Widowed/Viudo/a	☐ Partnered/Con Pareja	☐ Married/Casado/a	☐ Separated/Separado/a	☐ Divorced/Divorciado/a	
Previous or referring doctor/Medico anterior:			**Date of last physical exam/Ultimo examen fisico:**			

PERSONAL HEALTH HISTORY/HISTORIAL PERSONAL DE SALUD

Childhood illness:	☐ Measles	☐ Mumps	☐ Rubella	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio
Immunizations and dates/Fecha de vacunacion:	☐ Tetanus		☐ Pneumonia			
	☐ BCG		☐ HPV			
	☐ Influenza		☐ Varicella			

List any medical problems that other doctors have diagnosed/Problemas diagnosticados

Surgeries/Operaciones

Year/Año	Reason/Razon	Hospital

Other hospitalizations/Hospitalizaciones

Year/Año	Reason/Razon	Hospital

Have you ever had a blood transfusión? /Ha tenido alguna transfucion de sangre?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers/Lista de Medicamentos		
Name the Drug/Nombre de medicamento	Strength/Dosis	Frequency Taken/Frecuencia

Allergies to medications/Alergias a medicamentos	
Name the Drug/Nombre de medicamento	Reaction You Had/Reaccion

HEALTH HABITS AND PERSONAL SAFETY/HABITOS PERSONALES

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise/Ejercicio	☐ Sedentary (No exercise)/Nada de ejercicio					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)/Ejercicio ligero					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)/Menos de 4 veces por semana					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)/Ejercicio regular 4 veces por semana					
Diet/Dieta	Are you dieting? / Esta a dieta?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet? /Es dieta recetada por algun medico?				☐ Yes	☐ No
	# of meals you eat in an average day?/Cuantas comidas da al dia?					
	Rank salt intake/Consumo de Sal	☐ Hi/Alto	☐ Med/Moderado	☐ Low/Bajo		
	Rank fat intake/Consumo de grasa	☐ Hi/Alto	☐ Med/Moderado	☐ Low/Bajo		
Caffeine/Cafeina	☐ None/Nada	☐ Coffee/Cafe	☐ Tea/Te	☐ Cola/Coca		
	#of cups/cans per day?/Cuantas tazas por dia?					
Alcohol	Do you drink alcohol? /Toma alcohol?				☐ Yes	☐ No
	If yes, what kind? /Tipo?					
	How many drinks per week? /Cantidad por semana?					
	Are you concerned about the amount you drink? /Le preocupa la cantidad?				☐ Yes	☐ No
	Have you considered stopping? /Ha considerado dejarlo?				☐ Yes	☐ No
	Have you ever experienced blackouts? /Alguna vez ha sufrido desmayo?				☐ Yes	☐ No
	Are you prone to "binge" drinking? /Esta propenso a borrachera?				☐ Yes	☐ No
	Do you drive after drinking? /Maneja despues de tomar?				☐ Yes	☐ No
Tobacco	Do you use tobacco? /Usa tabaco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

Drugs/Drogas	Do you currently use recreational or street drugs? /Usa drogas ilegales?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle? /Ha inyectado drogas?	☐ Yes	☐ No
Sex/Sexo	Are you sexually active? /Es sexualmente activo?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy? / Esta tratando de embarazarse?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used/Contraceptivo:		
	Any discomfort with intercourse? /Tiene dolor con las relaciones?	☐ Yes	☐ No
	Would you like to speak with your provider about your risk of HIV?/Le gustaria hablar con el medico acerca de su riesgo de VIH?	☐ Yes	☐ No
Personal Safety/Seguridad Personal	Do you live alone? /Vive solo?	☐ Yes	☐ No
	Do you have frequent falls? /Ha sufrido caidas resiente?	☐ Yes	☐ No
	Do you have vision or hearing loss? /Tiene problemas para ver u oir?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will? /Tiene Directivas Avanzadas o testamento?	☐ Yes	☐ No
	Would you like information on the preparation of these? /Le gusaria informacion?	☐ Yes	☐ No
	Would you like to discuss physical, sexual or mental abuse with your provider?/Le gustaria hablar con el medico acerca de abuso fisico, sexual o emocional?	☐ Yes	☐ No

FAMILY HEALTH HISTORY/HISORIA FAMILIAR

	AGE/EDAD	SIGNIFICANT HEALTH PROBLEMS/PROBLEMAS DE SALUD		AGE/EDAD	SIGNIFICANT HEALTH PROBLEMS/PROBLEMAS DE SALUD
Father/Padre			**Children/ Hijos**	☐ M ☐ F	
Mother/ Madre				☐ M ☐ F	
Sibling/ Hermanos/as	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal/Abuela ma*		
	☐ M ☐ F		**Grandfather** *Maternal/Abuelo ma*		
	☐ M ☐ F		**Grandmother** *Paternal/Abuela pa*		
	☐ M ☐ F		**Grandfather** *Paternal/Abuelo pa*		

MENTAL HEALTH/SALUD MENTAL

Is stress a major problem for you? /Es el estres problema mayor para usted?	☐ Yes	☐ No
Do you feel depressed? /Se siente deprimido?	☐ Yes	☐ No
Do you panic when stressed? /Se atemoriza cuando se estreza?	☐ Yes	☐ No
Do you have problems with eating or your appetite? /Tiene algun problema con su apetito?	☐ Yes	☐ No
Do you cry frequently? / Llora con frecuencia?	☐ Yes	☐ No
Have you ever attempted suicide? / Alguna vez ha intentado el suicidio?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself? /Alguna vez ha pensado en dañarse?	☐ Yes	☐ No
Do you have trouble sleeping? /Tiene problema para dormir?	☐ Yes	☐ No
Have you ever been to a counselor? /Ha ido con algun consejero?	☐ Yes	☐ No

WOMEN ONLY/SOLO PARA MUJERES

Age at onset of menstruation/Edad de primera menstruacion:		
Date of last menstruation/Fecha de su ultima menstruacion:		
Period every days/Regla cada cuantos dias?		
Heavy periods, irregularity, spotting, pain, or discharge? /Tiene reglas pesadas ,irregular/dolor o deshecho?	☐ Yes	☐ No
Number of pregnancies/Numero de embarazos Number of live births/Numero de nacimientos		
Are you pregnant or breastfeeding? /Esta embarazada o dando pecho?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean? /Ha tenido un raspado,histerectomia,o cesaria?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year? /Ha tenido alguna infeccion de orina o del riñon en este año?	☐ Yes	☐ No
Any blood in your urine? /Ha tenido sangrado en la orina?	☐ Yes	☐ No
Any problems with control of urination? /Ha tenido problemas controlando la orina?	☐ Yes	☐ No
Any hot flashes or sweating at night? /Ha tenido calores o sudor de noche?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? /Tiene dolor,inflamacion,irritabilidado malestar con su regla?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge? /Ha tenido dolor, bolitas o deshecho del pezon?	☐ Yes	☐ No
Date of last pap and rectal exam? /Fecha de su ultimo papanicolau y examen rectal?		

MEN ONLY/SOLO PARA HOMBRES

Do you usually get up to urinate during the night/Se levanta a orinar de noche?	☐ Yes	☐ No
If yes, # of times/Cuantas veces		
Do you feel pain or burning with urination? /Siente dolor o ardor al orinar?	☐ Yes	☐ No
Any blood in your urine? /Tiene sangre en la orina?	☐ Yes	☐ No
Do you feel burning discharge from penis? /Siente ardor en el pene?	☐ Yes	☐ No
Has the force of your urination decreased? /Se ha disminuido la fuerza de la orina?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months? /Ha tenido infeccion en la vejiga,riñon o prostata en los ultimos 12 meses?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely? /Tiene problemas vaciando su vejiga completamente?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?/Ha tenido problemas con ereccion o eyaculacion?	☐ Yes	☐ No
Any testicle pain or swelling? /Ha tenido dolor o hinchazon en los testiculos?	☐ Yes	☐ No
Date of last prostate and rectal exam? /Fecha de su ultimo examen rectal y prostata?		

OTHER PROBLEMS/OTROS PROBLEMAS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain/Marque solo si tiene o ha tenido sintomas en estos areas y de una explicacion.

☐ Skin/Piel	☐ Chest/Heart;Pecho/Corazon	☐ Recent changes in/Cambios recientes en:
☐ Head/Neck;Cabeza/Cuello	☐ Back /Espalda	☐ Weight/Peso
☐ Ears /Oidos	☐ Intestinal/Intestino	☐ Energy level/Nivel de energia
☐ Nose/Nariz	☐ Bladder/Vejiga	☐ Ability to sleep/Abilidad de dormir
☐ Throat/Garganta	☐ Bowel/Escremento	☐ Other pain/discomfort/Algun otro dolor o molestia:
☐ Lungs/Pulmones	☐ Circulation/Circulacion	

UVALDE MEDICAL & SURGICAL ASSOCIATES

Patient Registration Form

Date: _____

Name: _____
Last **First** **Middle Initial**

Mailing Address: _____
Number **Street** **City** **Zip**

Social Security #_____ E-mail Address:_____

Birth Date _____Race _____ Home Ph # _____Cell Ph#_____

Single / Married / Separated / Divorced / Widowed Male / Female

Employer: _____ Work Ph # _____

Name of Primary Insurance Co. _____ Policy Number: _____

Name of Policyholder: _____

Name of Secondary Insurance Co._____ Policy Number: _____

Name of Policyholder: _____

Guarantor, Spouse, Parent _____

Social Security # _____ Birth Date _____ Relationship to Patient: _____

Guar. Address _____
Number **Street** **City** **Zip**

Employer: _____

Address: _____

Personal Health Information Release

(Any information relating to your personal health)

I hereby authorize Uvalde Medical and Surgical Associates to release personal health information on the above named individual to the following:

Name: _____ **Tel #:**_____

Name: _____ **Tel #:**_____

Name: _____ **Tel #:**_____

(This will include notification or change in appointments, notifications of lab or special study results, messages to return, call to the physician or nurse)

Patient or Authorized Person's Signature: _____

Uvalde Medical and Surgical Associates

INSURANCE AND FINANCIAL POLICIES

Thank you for choosing us for your health care. If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. If you do not, payment is expected at the time of service. Co-pay, co-insurance or deductibles are your responsibility and are due at the time of service.

Insurance:

You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that might be owed at the time of service. If you have questions about your coverage, speak to your employer or contact your insurer directly. Please present your health insurance card or policy information with you at the time of service.

In many cases we will be able to verify your coverage before your visit. If we are not able to verify insurance coverage, payment in full is expected at your visit. If your insurance company remits payment, you will be reimbursed.

Cancellation/Missed Appointments:

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 48 hours in advance of your appointment. Patients who do not give 48 hour notice will be charged a fee of $50.00.

Method of Payment:

We accept Cash, Checks, Debit, Visa, MasterCard, Discover and American Express.

Authorizations:

I have read the above information and agree regardless of my insurance to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my insurance coverage.

CONSENT and PAYMENT: I authorize Medicare/Medicaid/Insurance payments be made to Uvalde Medical and Surgical Associates and authorize release of medical information necessary to obtain payment of insurance benefits. I understand I am financially responsible for any balance not covered by my insurance and that a copy of this signature is as valid as the original. I hereby consent to treatment, lab work, use of prescribed medication and performance of diagnostic procedures/tests. I understand that this is given in advance of any specific diagnosis or treatment and that I have the right to refuse any service. This consent will remain in full force until revoked in writing and be continuing in nature.

Patient or Authorized Person's Signature: _____ **Date:** _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Uvalde Medical and Surgical Associates. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Uvalde Medical and Surgical Associates reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

Date _____ _____

Description of Personal Representative's Authority

Consent to Receive Electronic Communication

I authorize Uvalde Medical and Surgical Associates to send electronic communications such as email and text messaging to the email address and cell number I have provided, as needed.

_____ _____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative **Date**

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative **Date**

UVALDE MEDICAL AND SURGICAL ASSOCIATES -- STATEMENT OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uvalde Medical and Surgical Associates uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the **Uvalde Medical and Surgical Associates.**

How Uvalde Medical and Surgical Associates, May Use or Disclose Your Health Information

For Treatment. **Uvalde Medical and Surgical Associates** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to your actions. **Uvalde Medical and Surgical Associates** may use your health information when referring you to other health care professionals and facilities.

For Payment. **Uvalde Medical and Surgical Associates** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnoses, and treatment or supplies used in the course of treatment. **Uvalde Medical and Surgical Associates** may use your information to contact you about account balances. **Uvalde Medical and Surgical Associates** may use your information to access financial assistance programs for you that may help to defray the costs associated with your care or treatment.

For Health Care Operations. **Uvalde Medical and Surgical Associates** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your cases and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law. **Uvalde Medical and Surgical Associates** may use and disclose information about you as required by law. For example, **Uvalde Medical and Surgical Associates** may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls. **Uvalde Medical and Surgical Associates** may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification. **Uvalde Medical and Surgical Associates** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family. **Uvalde Medical and Surgical Associates'** health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to the person's involvement in your care or payment related to your care.

Business Associates. In some cases, **Uvalde Medical and Surgical Associates** contracts with business associates to provide services on its behalf. An example includes arrangements with business associates to provide collection services. **Uvalde Medical and Surgical Associates** may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, **Uvalde Medical and Surgical**

Associates requires the business associate to safeguard your information.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed to avert a serious threat to the health or safety of your or any other person pursuant to applicable law.

Food and Drug Administration (FDA). **Uvalde Medical and Surgical Associates** may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent **Uvalde Medical and Surgical Associates** has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures of your information; however, **Uvalde Medical and Surgical Associates** is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative locations; and
- Receive an accounting or disclosures made of your health information.

Obligations of Uvalde Medical and Surgical Associates

Uvalde Medical and Surgical Associates is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you make to communicate health information by alternative means or at alternative locations.

Uvalde Medical and Surgical Associates reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

Complaints

You may complain to **Uvalde Medical and Surgical Associates** and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.