NEW PATIENT MEDICAL HISTORY FORM

WASHINGTON COUNTY MEMORIAL HOSPITAL

Full Name: _____ Date: _____

Birth Date: _____ Age: _____ SSN#: _____

Local Pharmacy of Choice: _____

Mail Order Pharmacy of Choice: _____

DRUG AND FOOD ALLERGIES ☐ **NO ALLERGIES**

Allergy	Allergy Reaction

MEDICATIONS (including over the counter and herbal supplements)

Medications (Please List All)	Dose (Mg, Pill, Etc)	Times Per Day

If you need more room to list medications, please write them on a blank sheet of paper with the required information.

Please remember to bring medication bottles to all visits.

HEALTH MAINTENANCE/SCREENING TEST HISTORY

Cholesterol	Date:	Facility/Provider:	Abnormal Result? Y N
Colonoscopy	Date:	Facility/Provider:	Abnormal Result? Y N
Mammogram	Date:	Facility/Provider:	Abnormal Result? Y N
Pap Smear	Date:	Facility/Provider:	Abnormal Result? Y N
Bone Density	Date:	Facility/Provider:	Abnormal Result? Y N
Lung Cancer Screening	Date:	Facility/Provider:	Abnormal Result? Y N
Hep C Screening	Date:	Facility/Provider:	Abnormal Result? Y N
Aortic Aneurism Screening	Date:	Facility/Provider:	Abnormal Result? Y N
Prostate Exam/PSA	Date:	Facility/Provider:	Abnormal Result? Y N
HgbA1c	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or Tdap:	Last Pnuemovax (Pneumonia):
Last Flu Vaccine:	Last Prevnar (Pneumonia):
Last Zoster Vaccine (Shingles):	Covid (Brand/Date):

PERSONAL MEDICAL HISTORY

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma			
Anemia			
Anxiety/Depression			
Arthritis			
Blood Clots			
Cancer (type:_____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:_____)			
Emphysema (*COPD*)			
Gallbladder Disease			
GERD			
Heart Disease			
Hepatitis/Liver Disease			
High Blood Pressure (*Hypertension*)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Headaches/Migraines			
Irritable Bowel Disease			
Renal (*Kidney*) Disease			
Seizures			
Stroke			
Other:			

Patient Name: _____ DOB: _____

SURGERIES ☐ No Surgeries

Type (specify left/right)	**Date**	**Location/Facility**

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	
Current Birth Control:	Insertion Date if you have an IUD/Nexplanon:

MEN'S HEALTH HISTORY

History of Prostate trouble	YES	NO
Problems with erection/sexual difficulty	YES	NO
Penile Discharge	YES	NO
Do you examine your testicles	YES	NO

FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

Check All That Apply	ADD/ADHD	Alcohol/Drug Abuse	Asthma	Arthritis	Cancer	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Heart Disease	High Cholesterol	High Blood Pressure	Irritable Bowel Syndrome	Kidney Disease	Seizures	Stroke	Thyroid Disease	Migraines	Other:_____
Mother																			
Father																			
Brother																			
Sister																			
Maternal Grandmother																			
Maternal Grandfather																			
Paternal Grandmother																			
Paternal Grandfather																			
Other:_____																			

If any Family History of Cancer, please specify type of cancer: _____

_____

Patient Name: _____ DOB: _____

SOCIAL HISTORY

TOBACCO USE	Smoke Cigarettes? Y N *(if you never smoked, please SKIP to Alcohol/Drug Use)*
Current: Packs/day ____ # of Years Used____ ***Past:*** Quit Date: _____ Packs/day ____ # of Years Used ____	
Other Tobacco (circle one) Pipe Cigar Snuff Chew	
Age Tobacco Started: _____ and Age Tobacco Stopped: _____	
VAPING USE	Current user? Y N Age Started: _____ Age Stopped: _____
Vaping Device Type: _____ Frequency: _____	
Vaping *without* Nicotine? Y N If no, current strength of nicotine: _____	
ALCOHOL/DRUG USE	Do you drink alcohol? Y N Beer Wine Liquor # of Drinks/per week: ____
Do you use marijuana or recreational drugs? Y N	Do you have a medical marijuana card? Y N
Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N	
If yes, please list drugs used and age started:	
SEXUAL ACTIVITY	Sexually involved currently? Y N
Sexual partner(s) is/are/have been: *(circle all that apply)* Male Female	

Previous Primary Care Physician: _____ Location: _____

Last date of Visit at Previous PCP: _____ Reason for Leaving: _____

_____

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME/LOCATION	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Rheumatology		
Endocrinology		
Nephrology		
Urology		
Other:_____		
Other:_____		
Other:_____		
Other:_____		
Other:_____		

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS ***Please check all that apply***

Patient Name: _____ DOB: _____

WASHINGTON COUNTY MEMORIAL HOSPITAL

CONSTITUTION	PSYCHIATRIC	IMMUNOLOGIC
☐ Chills	☐ Anxiety	☐ Contact Allergies
☐ Fatigue	☐ Depression	☐ Environmental Allergies
☐ Fever	☐ Insomnia (difficulty sleeping)	☐ Food Allergies
☐ Malaise	**GASTROINTESTINAL**	☐ Seasonal Allergies
☐ Night Sweats	☐ Abdominal Pain	**NEUROLOGICAL**
☐ Weight Loss	☐ Blood in Stool	☐ Dizziness
☐ Weight Gain	☐ Change in Bowel Movement	☐ Extremity Numbness
HEAD, EAR, NOSE & THROAT	☐ Constipation	☐ Extremity Weakness
☐ Ear Drainage	☐ Diarrhea	☐ Gait Disturbance (difficulty walking)
☐ Ear Pain	☐ Heart Burn	☐ Headache
☐ Eye Discharge	☐ Loss of Appetite	☐ Memory Impairment
☐ Eye Pain	☐ Nausea/Vomiting	☐ Seizures
☐ Ear Pain	**METOBOLIC/ENDOCRINE**	☐ Tremors
☐ Hearing Loss	☐ Cold intolerance	**REPRODUCTIVE**
☐ Nasal Drainage	☐ Heat intolerance	☐ Dysmenorrhea (pain w/ menses)
☐ Sinus Pressure	☐ Polydipsia	☐ Dyspareunia (Pain with sex)
☐ Sore Throat	☐ Polyphagia	☐ Erectile Dysfunction
☐ Visual Changes	**GENITOURINARY**	☐ Hot Flashes
RESPIRATORY	☐ Dysuria (painful urination)	☐ Irregular Menses
☐ Cough	☐ Dribbling	☐ Penile Discharge
☐ Chronic Cough	☐ Polyuria – Lg Volume Urine	☐ Sexual Dysfunction
☐ Shortness of Breath	☐ Slow Urine Stream	☐ Vaginal Discharge
☐ Known TB Exposure	☐ Urinary Incontinence	☐
☐ Wheezing	☐ Urinary Frequency	☐
INTEGUNMENTARY	☐ Urinary Retention	**OTHER**
☐ Acne	**MUSCULOSKELETAL**	☐
☐ Breast Discharge	☐ Back Pain	☐
☐ Breast Lump	☐ Joint Swelling	☐
☐ Brittle Hair	☐ Joint Pain	☐
☐ Brittle Nails	☐ Muscle Weakness	☐
☐ Hair Loss	☐ Neck Pain	☐
☐ Hirsutism (Female Facial Hair)	**CARDIOVASCULAR**	☐
☐ Hives	☐ Chest Pain	☐
☐ Itching	☐ Claudication (Leg Pain)	☐
☐ Mole Changes	☐ Edema (swelling of legs)	☐
☐ Rash	☐ Palpitations	☐
☐ Skin Lesion	**HEMATOLOGIC/LYMPHATIC**	☐
☐	☐ Easy Bleeding	☐
☐	☐ Easy Bruising	☐
☐	☐ Swollen Lymph Nodes	☐

Berlin Questionnaire

Patient: _____ DOB: _____

CATEGORY 1

1. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

If you snore:

2. Your snoring is?
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Very loud. Can be heard in adjacent rooms

3. How often do you snore:
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ Never or nearly never

4. Has your snoring ever bothered other people?
   - ☐ Yes
   - ☐ No

5. Has anyone noticed that you quit breathing during sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after you sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

7. During your wake time, do you feel tired, fatigued, or not up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

   If yes, how often does it occur?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

CATEGORY 3

9. Do you have high blood pressure?
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

10. BMI > 30
   - ☐ Yes
   - ☐ No

Berlin Questionnaire results....

☐ POSTIVE OR ☐ NEGATIVE

Scoring Questions: Any question within the box is a positive response.

Scoring categories:
Category 1 is positive with 2 or more positive responses to questions 1-5.
Category 2 is positive with 2 or more positive responses to questions 6-8.
Category 3 is positive with 1 or more positive responses to questions 9-10.

Final Results: If 2 or more possible categories are positive,
you have a high likelihood of sleep apnea.

Health Way

Office Use Only: Electronic _____ Paper _____ Both ____

WASHINGTON COUNTY MEMORIAL HOSPITAL

Authorization for Release of Medical Information

Patient name: _____ Date of Birth: _____

Address: _____

Patient phone #: (_____)_____ Date of request _____ Date Processed _____
Authorize Electronic Release Of Records:_____Yes _____No _____ Personal email address delivery ONLY

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

☐ I authorize Health Way Primary Care **to release information to**:	**OR**	☐ I authorize the Health Way Primary Care **to obtain information from**:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)		_____ Phone #/Fax # (include area code)

1. **PURPOSE FOR THIS REQUEST: ( )** Transfer of Care **( )** Moving **( )** Personal **( )** School **( )** Legal **( )** Other (specify) _____
2. **TYPE OF RECORDS REQUESTED:**
   ( ) Immunization record **( )** Social Security/Disability Request **( )** Insurance Form **( )**Verification of status/diagnosis **( )** Laboratory test results _____ (please indicate date or test) **( )** Last one year of medical records **( )** Last two years of medical records **( )** Copy of all medical records **( )** Letter regarding treatment (please describe) _____**( )** Other (Please describe.) _____
3. **** IF your medical record contains any of the following sensitive information, HWPC will only release these records if you INITIAL authorization next to the type of information listed below: HIV information _____ Mental/Behavioral health information_____**
4. **Records should be ( )** Mailed to my home address **( )** Mailed or Faxed to agency below **( )** Left at HWPC for pick up
5. **Expiration Date of Request _____, If not completed this authorization expires 90 days after it is signed.**

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- This authorization is valid for this release only.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I understand that once information is released, used and/or shared, the person or organization that receives it may share it again. If this happens, the information may no longer be protected under applicable privacy laws.
- I understand the type of information that is being released, used and/or shared and how this will be done
- Release of HIV-related and mental/behavioral health information and treatment is highly sensitive and requires additional authorization (by initialing above).
- **There may be a charge for the requested records**.

Medical records are only faxed in cases of medical necessity.

Signature of Patient or Representative: _____Date: _____
Relationship to Patient *(if requester is not the patient):* _____

HWPC understands the importance of your request and strives to process your request as soon as possible; however due to the number of requests HWPC receives daily, requests are processed in the order in which they are received. Please let us know if the requested information is needed by a specific date and every effort will be made to meet your needs. **HWPC complies with HIPAA regulations which require processing of requests for medical information within 30 business days of request. -AND-**

- I understand that I may revoke this authorization at any time unless the Clinic has already taken action based on this form (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy).
- If I revoke this authorization, I must do so in writing.
- Additional information regarding the procedure for revoking this authorization will be in clinic's Notice of Privacy Practices, once available.
- I understand that I may refuse to sign this authorization. I also understand that the Clinic will not deny treatment because I refuse to sign this authorization.
- I understand that information disclosed based on this authorization may be redisclosed by the entity or the person who receives the information. Once disclosed, it is possible that the information will no longer be protected under federal medical privacy law.
- The use or disclosure of the requested information may result in direct or indirect payment to HWPC from a third-party, including copying fees.
- I may inspect or copy the protected health information to be used or disclosed subject to the discretion of my provider and as will be outlined in HWPC clinic's Policy for Right of Access to Protected Health Information, when available.
- The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act. Disclosures may only be made pursuant to a valid authorization by the client or as provided in Title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations (D.C. Code § 6-2004 (1995)).
- If the records or information being released involve treatment for alcohol or substance addiction, my records are also protected by federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records." (42 C.F.R. Part 2, 42 U.S.C. § 290dd-2).
- If the records or information released involve treatment for alcohol or substance addiction, this information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Witness: _____ Date:_____

Please fill out questionnaire and give to your provider.
This helps to determine if you are at risk for medical issues.
Please complete this page if 60 years and older.

Patient Name:_____ **Date:**_____

The Simple "FRAIL" Questionnaire

Please circle yes or no.

1. Are you fatigued? Yes (1) / No (0)
2. Are you able to walk up one flight of stairs without help? Yes (1) / No (0)
3. Are you able to walk one block without help? Yes (1) / No (0)
4. Do you have more than 5 illnesses? Yes (1) / No (0)
5. Have you lost more than 5% of your weight in the last 6 months? Yes (1) / No (0)

SARC-F Screen for Sarcopenia

*Please select only **one answer** per question.*

1. How much difficulty do you have in lifting and carrying 10 pounds? (Such as large bottle of detergent)
   Answer: ☐ None (0) ☐ Some (1) ☐ A lot or unable (2)

2. How much difficulty do you have walking across a room?
   Answer: ☐ None (0) ☐ Some (1) ☐ A lot or unable (2)

3. How much difficulty do you have getting up from a chair or bed?
   Answer: ☐ None (0) ☐ Some (1) ☐ A lot or unable (2)

4. How much difficulty do you have climbing a flight of 10 stairs?
   Answer: ☐ None (0) ☐ Some (1) ☐ A lot or unable (2)

5. Have you fallen in last year? If so, How many times? _____
   Answer: ☐ None (0) ☐ 1-3 Falls (1) ☐ 4 or more Falls (2)

SNAQ (Simplified Nutritional Assessment Questionnaire)

*Please **select only 1 answer** for the following 4 questions.*

1. My appetite is:
   a. very poor (1)
   b. poor (2)
   c. average (3)
   d. good (4)
   e. very good (5)

2. Food tastes:
   a. very bad (1)
   b. bad (2)
   c. average (3)
   d. good (4)
   e. very good (5)

3. When I eat:
   a. I feel full after eating only a few mouthfuls (1)
   b. I feel full after eating about *a third* of a meal (2)
   c. I feel full after eating *over half* a meal (3)
   d. I feel full after eating *most of* the meal (4)
   e. I hardly ever feel full (5)

4. Normally I eat:
   a. Less than one meal a day (1)
   b. One meal a day (2)
   c. Two meals a day (3)
   d. Three meals a day (4)
   e. More than three meals a day (5)