
# Patient Information

Name: _____Today's Date: _____

Date of Birth: _____Present Weight: _____

Street Address: _____

City: _____State: _____Zip: _____

Phone Numbers – Home: _____Cell: _____

Do you have an email address you can share with us? _____

Patient Employed by: _____

Business Address: _____

Business Phone: _____

Marital Status: (please circle) Married Single Divorced Widow

Spouse – Significant Other's Name: _____

Spouse – Significant Other's Phone Number: _____

In Case of Emergency, whom shall we notify? _____

Phone Number: _____
Preferred Pharmacy: _____
Location/Phone: _____

How did you hear about us?: (please circle) TV Radio Referral Other

If you were referred, by whom? _____

Signature:_____ Date: _____

HEART AND VITALITY

# Medical History

| | | | |
|---|---|---|---|
| 1. | Do you have diabetes? | Yes | No |
| 2. | Do you have hypertension? | Yes | No |
| 3. | Do you have heart disease? | Yes | No |
| 4. | Do you have a heart murmur? | Yes | No |
| 5. | Do you have/had kidney disease? | Yes | No |
| 6. | Have you ever been treated for psychiatric problems? | Yes | No |
| 7. | Have you had rheumatic fever? | Yes | No |
| 8. | Do you have mitral valve prolapse? | Yes | No |
| 9. | Have you ever been diagnosed with or been treated for cancer? | Yes | No |
| 10. | Have you ever had hepatitis/liver disease? | Yes | No |
| 11. | Have you had varicosities/phlebitis? | Yes | No |
| 12. | Do you have thyroid problems? | Yes | No |
| 13. | Have you had any major accidents? | Yes | No |
| 14. | Have you had a blood transfusion? | Yes | No |
| 15. | Do you have asthma/lung disease? | Yes | No |
| 16. | Do you have lupus? | Yes | No |
| 17. | Do you have arthritis? | Yes | No |
| 18. | Do you have any drug allergies? | Yes | No |
| 19. | Do you have diverticulitis? | Yes | No |

20. ***Please list all medications that you are currently taking including any Hormone Replacement Therapies***:_____

_____

_____

21. Please list any medications that you are allergic to: _____

_____

22. Please list any surgeries or hospitalizations: _____

_____

23. Other medical history for yourself or family: _____

HEART AND VITALITY

# Medical History-continued

1. Have you had a hysterectomy? (Please circle) Yes No Partial / Total
2. Are you pregnant? _____ Are you planning to become pregnant? _____
3. Are you breastfeeding? _____
4. How many times have you been pregnant? _____
5. How many miscarriages have you had? _____
6. Have you had any premature deliveries? _____
7. Are you sexually active? _____
8. Do you have pain with intercourse? _____
9. What type of contraception are you currently using? (Circle below)

| | | | | |
|---|---|---|---|---|
| Pills | Tubal Ligation | Condoms | Withdrawal | Depo Provera |
| Foam | Vasectomy | Diaphragm | Implants | Other |

10. Are you having problems with your method of birth control? _____
11. Date of last pap smear:_____
12. Have you ever had an abnormal pap smear? _____
13. Do you have trouble leaking urine? _____
14. Do you have any breast lumps, tenderness or discharge? _____
15. Have you had a mammogram? _____Date: _____ was it Normal? _____
16. Do you have PMS symptoms? _____
17. Do you have hot flashes or menopausal symptoms? _____
18. Do you have uterine anomalies? _____
19. If you no longer have periods, please state reasons:_____
20. First day of last period? _____
21. How many days do your period last? _____
22. Are your periods regular? _____
23. How many days from the start of one period to the start of the next period? _____
24. Do you have bleeding between periods? _____
25. Have you had an endometrial ablation? (Please circle) yes no

26. Do you have cramping with your period? _____If yes circle one: **MILD** **MODERATE** **SEVERE**

27. Do you smoke cigarettes: _____If yes, # per day: _____How many years? _____

28. Do you drink alcohol? _____ If yes, how often and how much do you consume? _____
_____

29. Do you use marijuana or any other illegal substances? _____ If yes, how often and what do you use? _____

Please feel free to provide us with any other information you feel is pertinent to your medical history. The more information we have the better we are able to assist you with your present symptoms.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please sign indicating all information provided is accurate and complete.

_____ _____
Patient Signature Date

# SYMPTOMS QUESTIONNAIRE

**Patient Name:** _____ **Date of Birth:** _____

Please circle one of the following categories below to let us know how you are feeling at today's appointment:

Current Status – What are your CURRENT symptoms?

**0** means you have no symptoms of this type at all / **1** means you have very mild symptoms of this type
**5** would be moderate symptoms of this type / **10** would mean you have severe symptoms of this type.

| | Low…… | | | | Moderate……. | | | | Severe…….. | | | Comments, if any |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sleep Disturbances | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Depression | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Anxiety | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Mood Swings | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Migraine Headaches | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Palpitations | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Painful Intercourse | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Night Sweats | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Hot Flashes | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Dry Skin | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Chronic Fatigue | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Restless Leg | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Hair Loss (women) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Fatigue | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Weight Control | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Low Sex Drive | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| (M) Erectile Dysfunc. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Poor Focus | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Body-Joint Pains | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Memory Lapses | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Low Exer. Tolerance | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |
| Loss of Muscle Tone | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | _____ |

(F)- First day of Last Menstrual Cycle: _____

Progesterone Dose (if applicable): _____

Daily Y N (circle one) would you like to change flavors? Y N (circle one)

Patient comments or any changes in medical conditions or medications since last report:

_____

_____

**ARE YOU DUE FOR REWNEWAL?** Y N (circle one)

**Patient Signature:** _____ **Date:** _____

## Notice of Privacy Practices

*Effective January 2003*

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.*

### Your Health Information & Rights

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information is referred to as your health or medical record. This Notice of Privacy Practices described how we may use or disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Although your health record is the property of this practice, the information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
2. Obtain a paper copy of this notice of privacy practices
3. Inspect and request a copy of your medical record as provided for in 45 CFR 164.524
4. Amend your health record as provided in 45 CFR 164.526
5. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
6. Request communications of your health information by alternative means and locations

### Heart and Vitality's Responsibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to your health information
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. The current Notice of Privacy Practices can be reviewed by contacting us by calling and requesting that a revised copy be sent to you in the mail. We will not use or disclose your health information without your authorization, except as described in this notice.

**For more information or to report a problem**

If you have questions and would like additional information, you may contact the Center Manager for our practice by calling (972) 668-7445. If you believe that your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

**Examples of Disclosures for Treatment, Payment and Health Care Operations:**

Heart and Vitality, PLLC will use your health information for treatment. Your health information may be released to other healthcare professionals within the hospital and the community for the purpose of providing you with quality healthcare. For example: Information obtained by one of our staff including physicians, nurses and administrative staff will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider, such as a nursing home, home health care agency or physical therapy office, with copies of various reports that will assist them in treating outside of this office.

We will use your health information for payment. For example: A bill may be sent to your or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

If you understand the above notice and information contained within, we ask that you sign and date that you acknowledge receipt of this information from our office. We will keep a copy of this signed notice in your medical record and provide you a copy for your own records. Thank you.

***Disclosures***

**Business Associates:** There are some services provided in our clinic through contracts with business associates. Examples include physician services in the emergency department and radiology, certain lab tests, transcription services and billing companies. Through a signed agreement, we require all business associates to comply with HIPAA laws and requirements to safeguard your health information.

**Notification:** We may use or disclose information to notify a family member, personal representative, or other person responsible for your care, your location and general condition.

**Communication with family:** Our staff, using their best judgment, may disclose to family member, other relative, close personal friend or any other person you identify, health information relevant to that persons involvement in your care or payment related to your care.

**Food & Drug Administration:** We 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.

**Workers Compensation:** We may disclose health information to the extent authorized to comply with Texas laws relating to the workers compensation program.

**Public Health:** As required by Texas law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Communicable Disease:** We may disclose health information as required by Texas law, to a person who may have been exposed to communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Abuse or Neglect:** We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agency authorized to receive such information.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Marketing & Patient Satisfaction Surveys:** We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

**Law Enforcement:** we may disclose health information for law enforcement purposes as required by Texas law or in response to a valid subpoena or court order.

**Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

**Military & Veterans:** If you are a member of the armed services, we may disclose health information as required by military command authorities.

## More Stringent Laws

We will evaluate whether your protected health information is governed by more stringent laws or regulations prior to our use or disclosure. There are other more stringent laws and rules, such as the federal substance abuse confidentiality regulations, the TX Mental Health confidentiality statute(s), the TX Public Health confidentiality provisions, and state minor consent statute(s), governing *status* (i.e., emancipation, marital status, etc.) or *type of treatment* (abortion, sexually transmitted disease, birth control, etc.), that may affect how we handle your information.

_____ _____

**Signature of Patient** (or Legal Representative) Date

HEART AND VITALITY

# Informed Consent

I, _____, acknowledge that I have been presented with a copy of the Heart and Vitality, PLLC Notice of Privacy Practices and am aware that all clinic personnel may that access to private information in order to serve patients.

I consent to the provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

Initial: _____ Date: _____

We may call to remind you of your appointment or to notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff to identify themselves, as well as myself, to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

Patients Signature: _____ Date: _____

I request that my protected health information be disclosed to the following persons or facility as listed below:

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____