



NEW PATIENT INFORMATION

12409 W. INDIAN SCHOOL RD., BLDG E
AVONDALE, AZ 85392
PHONE 623.536.5353
FAX 623.536.5829

FIRST NAME MI. LAST
ADDRESS
CITY STATE ZIP
EMPLOYER

SSN DATE OF BIRTH
HOME PHONE CELL PHONE
E-MAIL ADDRESS WORK PHONE
Male Female
WORK PHONE GENDER

SPOUSE'S INFORMATION (IF APPLICABLE)

FIRST NAME MI. LAST
HOME PHONE CELL PHONE

EMPLOYER WORK PHONE
E-MAIL ADDRESS

RESPONSIBLE PARTY OR PARENTS NAME (IF MINOR)

FIRST NAME MI. LAST
ADDRESS CELL PHONE
CITY STATE ZIP
EMPLOYER

SSN DATE OF BIRTH
HOME PHONE CELL PHONE
E-MAIL ADDRESS
WORK PHONE

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT

FIRST NAME MI. LAST
RELATIONSHIP PHONE

ADDRESS
CITY STATE ZIP

PREFERRED PHARMACY INFORMATION

NAME PHONE CROSS STREETS

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

PRIMARY INSURANCE COMPANY NAME
SUBSCRIBER'S NAME
SUBSCRIBER'S SSN DATE OF BIRTH
SELF SPOUSE DEPENDENT OTHER
PATIENT'S RELATIONSHIP TO INSURED

SECONDARY INSURANCE COMPANY NAME
SUBSCRIBER'S NAME
SUBSCRIBER'S SSN DATE OF BIRTH
SELF SPOUSE DEPENDENT OTHER
PATIENT'S RELATIONSHIP TO INSURED

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY BALANCE NOT PAID BY YOUR INSURANCE.

Co-Pays will be collected at the START of each visit.

BY SIGNING THIS RELEASE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM AND I HEREBY REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER AGENCY REIMBURSEMENTS. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SUN VALLEY MEDICAL GROUP TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGNATURE DATE

PLEASE COMPLETE THE BACK OF THIS FORM



HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

12409 W. INDIAN SCHOOL RD., BLDG E
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THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE UNDERSTAND AND BELIEVE THAT THE INFORMATION ABOUT YOU AND YOUR HEALTH CARE ARE BOTH IMPORTANT AND VERY CONFIDENTIAL. WE ARE COMPLETELY COMMITTED TO PROTECTING HEALTH INFORMATION ABOUT YOU. ADDITIONALLY, THE LAW REQUIRES US TO PROTECT THE PRIVACY OF YOUR HEALTH AND PERSONAL INFORMATION AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES, WITH RESPECT TO SAID INFORMATION. THIS NOTICE OUTLINES OUR LEGAL OBLIGATIONS REGARDING YOUR HEALTH INFORMATION. PLEASE READ IT CAREFULLY AND FEEL FREE TO ASK QUESTIONS IF YOU HAVE ANY.

THE LAW REQUIRES US TO:

1. KEEP YOUR MEDICAL INFORMATION PRIVATE AND PROTECTED.
2. GIVE YOU THE NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES REGARDING YOUR HEALTH INFORMATION.
3. FOLLOW THE TERMS OF THIS CURRENT NOTICE.

USE AND DISCLOSURE OF HEALTH INFORMATION ABOUT YOU:

THE FOLLOWING CATEGORIES DESCRIBE DIFFERENT WAYS THAT WE USE AND DISCLOSE HEALTH INFORMATION. NOT EVERY USE OF DISCLOSURE IS LISTED. HOWEVER, ALL OF THE WAYS THAT LAW PERMITS US TO USE AND DISCLOSE INFORMATION WILL FALL INTO ONE OF THE FOLLOWING CATEGORIES. WE WILL NOT USE OR DISCLOSE YOUR HEALTH INFORMATION FOR ANY PURPOSE OTHER THAN DESCRIBED BELOW, WITHOUT YOUR WRITTEN CONSENT.

FOR TREATMENT – WE MAY USE YOUR HEALTH INFORMATION TO PROVIDE YOU WITH HEALTH TREATMENTS AND SERVICES. WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU TO DOCTORS, NURSES, TECHNICIANS, MEDICAL STUDENTS, OR ANY OTHER PEOPLE WHO ARE INVOLVED IN YOUR TREATMENT. THESE INDIVIDUALS MAY WORK DIRECTLY IN OUR OFFICES, IN A HOSPITAL IF YOU ARE HOSPITALIZED, IN A LABORATORY, IN A PHARMACY OR MAY BE ANY HEALTH CARE PROVIDER TO WHOM WE REFER YOUR CONSULTATION OR TREATMENT. WE MAY ALSO DISCLOSE HEALTH INFORMATION ABOUT YOU TO ANY ENTITY ASSISTING IN A DISASTER RELIEF EFFORT SO THAT YOUR FAMILY MEMBERS CAN BE NOTIFIED ABOUT YOUR CONDITION, STATUS AND LOCATION.

FOR PAYMENT – YOUR PROTECTED HEALTH INFORMATION MAY BE USED FOR OBTAINING PAYMENT FOR YOUR HEALTH CARE SERVICES. THIS MAY INCLUDE ACTIVITIES THAT YOUR HEALTH INSURANCE CARRIER UNDERTAKES PRIOR TO THEIR APPROVAL OR PAYS FOR THE HEALTHCARE SERVICES WE RECOMMEND FOR YOU SUCH AS: MAKING A DETERMINATION OF ELIGIBILITY OR COVERAGE FOR INSURANCE BENEFITS, REVIEWING SERVICES PROVIDED TO YOU FOR MEDICAL NECESSITY AND UNDERTAKING UTILIZATION REVIEW ACTIVITIES.

HEALTHCARE OPERATIONS – WE MAY USE OR DISCLOSE, AS NEEDED, YOUR PROTECTED INFORMATION IN ORDER TO SUPPORT THE BUSINESS ACTIVITIES OF YOUR PHYSICIAN'S PRACTICE. THESE ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, QUALITY ASSESSMENT ACTIVITIES. FOR EXAMPLE, WE MAY DISCLOSE YOUR PROTECTED INFORMATION TO MEDICAL SCHOOL STUDENTS THAT SEE PATIENTS IN OUR OFFICE. IN ADDITION, WE MAY USE A SIGN IN SHEET AT THE REGISTRATION DESK WHERE YOU WILL BE ASKED TO SIGN YOUR NAME AND INDICATE YOUR PHYSICIAN. WE MAY ALSO CALL YOU BY NAME IN THE WAITING ROOM WHEN YOUR PHYSICIAN IS READY TO SEE YOU. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT.

COMMUNICATION WITH FAMILY AND FRIENDS – WE WILL DISCLOSE YOUR HEALTH INFORMATION TO YOUR FAMILY MEMBERS AND FRIENDS IF YOU ARE IN OUR FACILITY AND CONSCIOUS AND YOU ALLOW SUCH DISCLOSURE OR IT IS REASONABLE TO ASSUME FROM THE CIRCUMSTANCES THAT YOU ALLOW SUCH DISCLOSURE. FOR EXAMPLE, IF YOU ALLOW A FAMILY MEMBER OR FRIEND TO ACCOMPANY YOU TO YOUR APPOINTMENT AND TO THE EXAM ROOM WITH YOU THEN IT IS REASONABLE TO ASSUME THAT YOU ARE ALLOWING SUCH DISCLOSURE ABOUT YOUR PROTECTED HEALTHCARE. IF YOU ARE NOT IN OUR OFFICE/FACILITY OR IN INCAPACITATED, OUR HEALTH CARE PRACTITIONERS WILL EXERCISE PROFESSIONAL JUDGMENT TO DETERMINE WHETHER A DISCLOSURE TO YOUR FAMILY, PERSONAL REPRESENTATIVE, OR OTHER PERSONS RESPONSIBLE FOR YOUR CARE IS IN YOUR BEST INTEREST. THE PRACTITIONER WILL ONLY DISCLOSE INFORMATION DIRECTLY RELEVANT TO THE RECIPIENT'S INVOLVEMENT IN YOUR HEALTH CARE OR PAYMENT OF HEALTH CARE.

NOTIFICATION – WE MAY ALSO DISCLOSE YOUR HEALTH INFORMATION TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, YOUR PERSONAL REPRESENTATIVE, OR OTHER PERSONS RESPONSIBLE FOR YOUR CARE ABOUT YOUR LOCATION, GENERAL CONDITION OR DEATH.

PUBLIC HEALTH AGENCIES – WE MAY DISCLOSE YOUR HEALTH INFORMATION FOR PUBLIC HEALTH ACTIVITIES SUCH AS ASSISTING PUBLIC HEALTH AUTHORITIES IN PREVENTING OR TRACKING DISEASE OR OUTBREAKS AND MAINTAINING CUSTOMER RECORDS OF MEDICAL SUPPLIES IN THE EVENT OF PRODUCT RECALL. WE ARE REQUIRED TO REPORT INITIAL DIAGNOSIS OF SEXUALLY TRANSMITTED DISEASES (STD) AND COMMUNICABLE DISEASES TO STATE PUBLIC HEALTH AGENCIES.

HEALTH, SAFETY AND LAW ENFORCEMENT – WE ARE REQUIRED TO DISCLOSE INFORMATION TO LAW ENFORCEMENT IF WE SUSPECT CHILD ABUSE OR NEGLECT. IN THE EXERCISE OF OUR PROFESSIONAL JUDGMENT, WE MAY REPORT INFORMATION IN THE CASE OF ADULT ABUSE. YOUR HEALTH INFORMATION MAY BE DISCLOSED TO AVERT A SERIOUS THREAT TO HEALTH AND SAFETY OR ANY OTHER PERSON. WE WILL DISCLOSE INFORMATION IF WE ARE REQUIRED TO DO SO BY LAW, SUCH AS PURSUANT TO JUDICIAL OR ADMINISTRATIVE SUBPOENA. WE MAY ALSO BE REQUIRED TO DISCLOSE INFORMATION FOR SPECIALIZED GOVERNMENT FUNCTIONS SUCH AS PROTECTION OF PUBLIC OFFICIALS OR REPORTING TO VARIOUS BRANCHES OF THE ARMED SERVICES. FINALLY, WE MAY DISCLOSE HEALTH INFORMATION TO ASSIST LAW ENFORCEMENT OFFICIALS IN THEIR DUTIES.



HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

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HEALTH INFORMATION – WE MIGHT SEND YOU GENERAL NEWSLETTERS OR OTHER INFORMATION THAT PROMOTES YOUR HEALTH AS WELL AS OTHER HELPFUL INFORMATION REGARDING OUR FACILITY.

OTHER – HEALTH INFORMATION MAY BE DISCLOSED TO FUNERAL DIRECTORS OR CORONERS TO ENABLE SUCH PERSONS TO PERFORM THEIR DUTIES. YOUR HEALTH INFORMATION MAY ALSO BE USED OR DISCLOSED FOR CADAVER ORGAN, EYE OR TISSUE DONATION PURPOSES. YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED IN ORDER TO COMPLY WITH LAWS AND REGULATIONS RELATED TO WORKER'S COMPENSATION. WE WILL SHARE YOUR PROTECTED HEALTH INFORMATION WITH THIRD PART BUSINESS ASSOCIATES THAT PERFORM VARIOUS ACTIVITIES (E.G., BILLING) FOR THE CLINIC. WHENEVER AN ARRANGEMENT BETWEEN OUR OFFICE AND A BUSINESS ASSOCIATED INVOLVES THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION WE WILL HAVE A WRITTEN CONTRACT THAT CONTAINS TERMS THAT WILL PROTECT THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION.

OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION AND YOU MAY REVOKE THE AUTHORIZATION EXCEPT TO THE EXTENT WE HAVE TAKEN ACTION IN RELIANCE UPON AUTHORIZATION.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

YOU HAVE CERTAIN RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION. THESE RIGHTS ARE LISTED BELOW. IF YOU WOULD LIKE TO EXERCISE ANY OF THESE RIGHTS OR IF YOU HAVE QUESTIONS REGARDING YOUR RIGHTS, PLEASE CONTACT: DIRECTOR OF OPERATIONS **BRAD HIXON** 623-935-7788.

1. YOU HAVE THE RIGHT TO REQUEST THAT WE LIMIT OUR USES AND DISCLOSURES OF YOUR HEALTH INFORMATION. WE HAVE THE RIGHT TO NOT AGREE TO YOUR REQUEST.
2. YOU HAVE THE RIGHT TO REQUEST THAT WE COMMUNICATE WITH YOU THROUGH ALTERNATIVE MEANS OR LOCATIONS, AND WE WILL RESPECT ANY REASONABLE REQUESTS.
3. YOU HAVE THE RIGHT TO REVIEW AND OBTAIN A COPY OF YOUR HEALTH INFORMATION WITH A WRITTEN MEDICAL RECORDS RELEASE SIGNED AND DATED. WE HAVE THE RIGHT TO CHARGE YOU A FEE FOR THE COST OF PROVIDING YOU WITH SUCH COPIES.
4. YOU HAVE THE RIGHT TO REQUEST THAT WE AMEND YOUR HEALTH INFORMATION. WE WILL REVIEW YOUR REQUEST BUT NOT NECESSARILY MAKE THE AMENDMENTS YOU REQUEST.
5. YOU HAVE THE RIGHT TO OBTAIN AN ACCOUNTING OF DISCLOSURES THAT WE HAVE MADE YOUR HEALTH INFORMATION EXCEPT DISCLOSURE FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, DISCLOSURES AUTHORIZED BY YOU, AND DISCLOSURES FOR CERTAIN GOVERNMENT FUNCTIONS.
6. YOU HAVE THE RIGHT TO REVOKE ANY AUTHORIZATION YOU MADE FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION EXCEPT TO THE EXTENT WE HAVE ALREADY RELIED ON THE AUTHORIZATION. YOU HAVE THE RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE.

WE ARE REQUIRED BY LAW TO ABIDE BY THE TERMS OF THIS NOTICE OF PRIVACY PRACTICES. WE HAVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AT ANYTIME. THE NEW NOTICE WILL BE EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN AT THIS TIME. WE WILL COMMUNICATE ANY CHANGES BY PROVIDING YOU WITH A NEW COPY OF THE NOTICE OF PRIVACY PRACTICES THE NEXT TIME YOU RECEIVE TREATMENT AT OUR FACILITY AFTER ANY SUCH CHANGE.

COMPLAINTS – YOU MAY MAKE YOUR COMPLAINTS TO US OR TO THE OFFICE OF CIVIL RIGHTS IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY US. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING THE DIRECTOR OF OPERATION AT SUN VALLEY MEDICAL GROUP. YOU MAY OBTAIN THE ADDRESS OF THE OCR REGIONAL MANAGER, DENVER, CO, FROM OUR DIRECTOR OF OPERATIONS.

CLINIC NAME AND PHONE NUMBER
SUN VALLEY MEDICAL GROUP, 623-935-7788

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON: **DECEMBER 30, 2008**

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER (DIRECTOR OF OPERATIONS) IN PERSON OR BY PHONE AT CLINIC PHONE NUMBER 623-935-7788.



FAMILY PRACTICE POLICES

12409 W. INDIAN SCHOOL RD., BLDG E
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NOTICE OF PRIVACY PRACTICE

YOUR NAME AND SIGNATURE ON THIS SHEET INDICATES THAT YOU HAVE READ A COPY OF SUN VALLEY FAMILY PRACTICE NOTICE OF PRIVACY PRACTICES ON THE DATE INDICATED. IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION SET FORTH IN SUN VALLEY FAMILY PRACTICES NOTICE OF PRIVACY PRACTICES PLEASE DO NOT HESITATE TO CONTACT US AT (623) 218-6907.

NAME (PLEASE PRINT)

DATE

SIGNATURE

APPOINTMENT/CANCELLATION POLICY

APPOINTMENTS

OFFICE VISITS ARE TYPICALLY BY APPOINTMENT ONLY. PLEASE CALL THE FRONT OFFICE TO SCHEDULE YOUR APPOINTMENT. THE FRONT DESK WILL COLLECT INFORMATION ABOUT YOUR AVAILABILITY, THE NATURE OF THE VISIT, AND YOUR CONTACT INFORMATION. THIS INFORMATION ASSISTS US IN BEING PROPERLY PREPARED FOR YOUR VISIT.

CANCELLATIONS

IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, YOU ARE EXPECTED TO CANCEL AT LEAST 24 HOURS IN ADVANCE. IF THIS IS NOT POSSIBLE, PLEASE CALL AS SOON AS POSSIBLE SO THAT ANOTHER PATIENT CAN BE GIVEN THAT APPOINTMENT TIME. ONLY THOSE APPOINTMENTS CANCELLED AT LEAST 24 HOURS IN ADVANCE CAN BE GUARANTEED NOT TO INCUR A MISSED APPOINTMENT FEE.

ARRIVING LATE FOR APPOINTMENTS

PATIENTS WHO ARRIVE LATE FOR THEIR APPOINTMENT MAY BE ASKED TO RESCHEDULE. PLEASE NOTE THAT IT IS VERY IMPORTANT THAT YOU ARRIVE TO YOUR APPOINTMENT ON TIME.

MISSED APPOINTMENTS

WE UNDERSTAND THAT OCCASIONAL EMERGENCIES CAN OCCUR FOR A VARIETY OF REASONS THAT MAY CAUSE A MISSED APPOINTMENT. IF YOU MISS AN APPOINTMENT BECAUSE OF A PERSONAL EMERGENCY, WE WILL BE MORE THAN HAPPY TO RESCHEDULE YOUR APPOINTMENT.

ALL MISSED APPOINTMENTS, REGARDLESS OF THE REASON, ARE TRACKED BY OUR STAFF. NOT FOLLOWING THE PROPER PROCEDURE OF CANCELING AN APPOINTMENT AT LEAST 24 HOURS IN ADVANCE MAY INCUR A MISSED APPOINTMENT FEE. YOUR INSURANCE WILL NOT COVER ANY CHARGES FOR MISSED APPOINTMENTS.

WHEN A PATIENT HAS MISSED 3 APPOINTMENTS IN A ONE YEAR PERIOD, THEY WILL BE SENT A LETTER DISCHARGING THEM FROM THE PRACTICE.

I HAVE READ AND ACKNOWLEDGE SUN VALLEY MEDICAL GROUP'S APPOINTMENT/CANCELLATION POLICY.

NAME (PLEASE PRINT)

DATE

SIGNATURE



HEALTH HISTORY ADULT

12409 W. INDIAN SCHOOL RD., BLDG E
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NAME

DATE

ADULT HEALTH HISTORY FORM

THE ANSWERS YOU PROVIDE ON THIS FORM WILL HELP OUR PROVIDERS BETTER UNDERSTAND YOUR MEDICAL CONCERNS AND CONDITIONS. IF YOU FEEL UNCOMFORTABLE ANSWERING ANY OF THESE QUESTIONS, SIMPLY MOVE ON TO THE NEXT QUESTION. IF YOU CANNOT REMEMBER SPECIFIC INFORMATION SUCH AS DATES, A BEST ESTIMATE IS FINE. **THANK YOU FOR YOUR HELP!**

PRESENT HEALTH CONCERNS:

MEDICATIONS: PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS, VITAMINS, HOME REMEDIES, BIRTH CONTROL PILLS, HERBS, ETC.

MEDICATION	DOSE	TIMES PER DAY

MEDICATION	DOSE	TIMES PER DAY

ALLERGIES TO MEDICATIONS:

HEALTH MAINTENANCE SCREENING TESTS:

LIPID (CHOLESTEROL) DATE: _____ ABNORMAL? YES NO

COLONOSCOPY DATE: _____ ABNORMAL? YES NO

WOMEN:

MAMMOGRAM DATE: _____ ABNORMAL? YES NO

PAP SMEAR DATE: _____ ABNORMAL? YES NO

DEXASCAN DATE: _____ ABNORMAL? YES NO
(OSTEOPOROSIS)

MEN:

PSA (PROSTATE) DATE: _____ ABNORMAL? YES NO



HEALTH HISTORY ADULT

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PERSONAL MEDICAL HISTORY: PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS (WITH DATES).

_____ HEART DISEASE: SPECIFY TYPE _____	_____ HIGH BLOOD PRESSURE _____ DIABETES _____ OTHER (SPECIFY): _____	_____ HIGH CHOLESTEROL _____ THYROID PROBLEM _____ KIDNEY DISEASE
_____ ASTHMA/LUNG DISEASE _____ CANCER SPECIFY TYPE _____		

SURGICAL HISTORY: PLEASE LIST ALL PRIOR OPERATIONS (WITH DATES):

FAMILY HISTORY: PLEASE INDICATE THE CURRENT STATUS OF YOUR IMMEDIATE FAMILY MEMBERS:(INDICATE FOR FAMILY MEMBERS: PARENTS, SIBLINGS, AND GRANDPARENTS).

ALCOHOLISM _____	HIGH CHOLESTEROL _____
CANCER (TYPE) _____	HIGH BLOOD PRESSURE _____
HEART DISEASE _____	STROKE _____
DEPRESSION _____	BLEEDING/CLOTTING DISORDER _____
GENETIC DISORDERS _____	ASTHMA/COPD _____
DIABETES _____	OTHER _____

IMMUNIZATIONS: PLEASE PROVIDE AN UP TO DATE COPY OF YOUR IMMUNIZATION RECORD. IF THIS IS NOT AVAILABLE, PLEASE COMPLETE LIST BELOW OF YOUR MOST RECENT IMMUNIZATIONS. PLEASE INCLUDE YOUR BEST ESTIMATE OF THE MONTH AND YEAR OF EACH IMMUNIZATION.

HEPATITIS A _____	MEASLES _____	MUMPS _____	RUBELLA _____	ZOSTIVAX (SHINGLES) _____
HEPATITIS B _____	MMR _____			PNEUMOVAX _____
TETANUS (Td) _____	VARICELLA (CHICKEN POX) _____			OTHER _____

DO YOU NORMALLY GET THE ANNUAL FLU VACCINE? Yes No

WOMEN'S GYNECOLOGIC HISTORY:

PREGNANCIES _____ # DELIVERIES _____ # ABORTIONS _____ # MISCARRIAGES _____

1ST DAY OF MOST RECENT PERIOD _____ AGE AT 1ST PERIOD _____

FREQUENCY OF PERIODS _____ LENGTH OF EACH _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR PERIODS? Yes No

DO YOU HAVE ANY CONCERNS ABOUT MENOPAUSE? Yes No



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SOCIAL HISTORY:

TOBACCO USE

CIGARETTES NEVER QUIT DATE _____ CURRENT SMOKER: PACKS/DAY _____ # YEAR _____
OTHER TOBACCO PIPE CIGAR CHEW ARE YOU INTERESTED IN QUITTING? YES NO

ALCOHOL USE

DO YOU DRINK ALCOHOL? YES NO #/WEEK _____ IS ALCOHOL USE A CONCERN TO YOU OR OTHERS? YES NO

DRUG USE

DO YOU USE ANY RECREATIONAL DRUGS? YES NO HAVE YOU EVER USED NEEDLES TO INJECT DRUGS? YES NO

SEXUAL ACTIVITY

SEXUALLY ACTIVE: YES NO NOT CURRENTLY CURRENT SEX PARTNER(S) IS/ARE: MALE FEMALE
BIRTH CONTROL METHOD: _____ NONE NEEDED HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (STD)? YES NO
NO ARE YOU INTERESTED IN BEING TESTED FOR STD'S? YES NO

OTHER CONCERNS:

CAFFEINE INTAKE: NONE COFFEE/TEA/SODA ____/DAY
WEIGHT: ARE YOU SATISFIED WITH YOUR WEIGHT? YES NO
DIET: HOW DO YOU RATE YOUR DIET? GOOD FAIR POOR
DO YOU EAT OR DRINK 4 SERVINGS OF DAIRY OR SOY DAILY OR TAKE CALCIUM SUPPLEMENTS? YES NO

EXERCISE: DO YOU EXERCISE REGULARLY? YES NO TYPE OF EXERCISE: _____
HOW LONG: _____ HOW OFTEN: _____ IF NO, WHY? _____
MARITAL STATUS: S M D W OTHER _____ SPOUSE/PARTNER'S NAME: _____
OF CHILDREN: _____ WHO LIVES IN YOUR HOME: _____

SAFETY:

DO YOU USE SEATBELTS CONSISTENTLY? YES NO IS VIOLENCE AT HOME A CONCERN FOR YOU? YES NO
DO YOU FEEL SAFE IN YOUR RELATIONSHIPS? YES NO

REVIEW OF SYSTEMS: PLEASE CHECK ANY CURRENT PROBLEMS YOU HAVE ON THE FOLLOWING LIST

CONSTITUTIONAL

___ FEVERS/CHILLS/SWEATS
___ UNEXPLAINED WEIGHT LOSS/GAIN
___ FATIGUE/WEAKNESS
___ EXCESSIVE THIRST OR URINATION EYES
___ CHANGE IN VISION

EARS/NOSE/THROAT/MOUTH

___ DIFFICULTY HEARING
___ RINGING IN EARS
___ PROBLEMS W/TEETH OR GUMS
___ HAY FEVER/ALLERGIES

CARDIOVASCULAR

___ CHEST PAIN/DISCOMFORT
___ LEG PAIN W/EXERCISE
___ PALPITATIONS

CHEST (BREAST)

___ BREAST LUMP/DISCHARGE

RESPIRATORY

___ COUGH/WHEEZE
___ DIFFICULTY BREATHING

GASTROINTESTINAL

___ ABDOMINAL PAIN
___ BLOOD IN BOWEL MOVEMENT
___ NAUSEA/VOMITING/DIARRHEA

GENITOURINARY

___ NIGHTTIME URINATION
___ LEAKING URINE
___ DISCHARGE: PENIS OR VAGINA
___ Unusual vaginal bleeding
___ Sexual function problems

MUSCULO-SKELETAL

___ MUSCLE-JOINT PAIN

BLOOD/LYMPHATIC

___ UNEXPLAINED LUMPS
___ EASY BRUISING/BLEEDING

SKIN

___ RASH OR MOLE CHANGE

NEUROLOGICAL

___ HEADACHES
___ DIZZINESS
___ LIGHT-HEADEDNESS
___ NUMBNESS
___ MEMORY LOSS
___ LOSS OF COORDINATION

PSYCHIATRIC

___ ANXIETY/STRESS
___ SLEEP PROBLEMS

OTHER
