AdventResearch

Patient Demographics **Today's Date:_____**

First name: _____ Middle Name: _____Last Name: _____

Birthdate: _____ Age:_____ SSN (optional)_____

Gender	Education	Race	Ethnicity
_Male	_Grade School	_American Indian/Alaska Native	_Hispanic/Latino
_Female	_High School	_Asian	_Non hispanic/Latino
	_Technical School	_Black or African American	
	_2 Year College	_Caucasian	
	_Bachelor's	_Native Hawaiian/Pacific Islander	
	_Doctorate		
	_Post Graduate		

Address:_____

City:_____ State:_____ Zip Code:_____

Home Number:_____ Work Number: _____

Cell Number: _____ Email Address_____

Are we able to contact you at work? ☐Yes ☐No
Are we able to contact you via email? ☐Yes ☐No
Can we leave a message on your voicemail? ☐Yes ☐No
Can we leave a text message on your cell phone? ☐Yes ☐No

Emergency Contact Name:_____ Relationship to you:_____

Best Contact Number:_____

Physician's Name:_____ Phone Number:_____

Pharmacy Name:_____ Phone Number:_____

I certify that the information contained in this medical history is true and complete to the best of my knowledge. I agree to hold harmless defend and indemnify Advent Research and it's physicians and staff from any and all liability resulting from any incorrect or misleading information I have provided.

Signature:_____

The following is an authorization to share any medical procedure results. You may elect to share those results or not to share those results. Your choice does not affect your participation in a study. Please select from one of the following:

_____ If I chose to participate in a study, I elect to have any test results shared with my Primary Care Physician

_____ If I choose to participate in a study, I do NOT elect to have any test results shared with my Primary Care Physician.

_____ If I choose to participate in a study, I elect to have any test results shared with another physician, other than my Primary Care Physician and designate:

_____ I do not have a Primary Care Physician to share any test results with

_____ _____

Signature of Patient Date

_____ _____

Printed name of Patient Date

Contraception History (Females only)

Please indicate ALL methods of contraception you have used in the past 3 years and indicate the START and STOP dates for each method.

Method	Started (month/year)	Stopped (month/year)
Abstinence (not sexually active)		
Oral Contraceptives (birth control Pills)		
Condoms with spermicide		
Condoms without spermicide		
Diaphragm		
Vaginal gel or foam (spermicidal)		
Intrauterine Device (IUD)		
Transdermal Patch		
Topical Gel		
Vaginal Ring		
Norplant (5 year implant)		
Depo-Provera (monthly injection-date most recent injection)		

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Current Medications

Please list ALL medications you are taking currently, or have taken within the past 90 days. Include all prescriptions, over the counter medications, vitamins, dietary supplements, weight loss products, and herbal preparations. Ask for an additional sheet if needed.

Medication	Dose	Frequency	Diagnosis/Indication	Start date/Stop Date

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Family Medical Overview

Relation	Age Now or Age at Death	Current Health Conditions or Cause of Death
Father		
Mother		
Brothers		
Sisters		

Occupational Exposure and Risk:

What is your current occupation? _____

What are your normal working hours? _____

Do you work rotating shifts? ☐Yes ☐No

Are you "on-call"? ☐Yes ☐No

Does your work schedule change suddenly, or without notice? ☐Yes ☐No

Does your job and/or lifestyle expose you to:

- ☐ Physical Stress
- ☐ Emotional Stress
- ☐ Heavy Lifting
- ☐ Hazardous substances
- ☐ Climate Extremes
- ☐ Other:_____

Physical Diagnosed Illnesses or Conditions

Please list any hospitalizations, surgeries, or serious injuries.

_____

_____

_____

_____

Please list any allergies. Include DRUG/MEDICATIONS, ENVIRONMENTAL, and SEASONAL allergies

Allergic to: (example – Tylenol)	Type of Reaction: (example – face swelling)

Please check ALL PAST and CURRENT illnesses or conditions DIAGNOSED by a physician.
DO NOT check items that you have self-diagnosed, or that you believe you may have experienced.

Constitional:	**Gastrointestinal**	**Hepatobiliary**
□ Good General health lately	□ GERD	□ Cirrhosis
□ Recent weight change	□ Diverticulitis	□ Gall Stones
□ Fever/night sweats	□ Colitis	□ Hepatitis
□ Fatigue	□ Nausea or vomiting	□ Pancreatitis
Eyes	□ Diarrhea	□ Cholecystitis
□ Cataracts	□ Constipation	□ Fatty Liver
□ Eye disease or injury	□ Ulcers	**Endocrine system**
□ Corrective Lenses	□ Dyspepsia/Indigestion	□ Type II Diabetes
□ Blurred or double vision	□ Irritable Bowel Syndrome	□ Hypothroidism (under active thyroid)
□ Glaucoma	□ Hemorrhoids	□ Hypoglycemia
Ear/Nose/Mouth/Throat	□ Colon Polyps	□ Type I Diabetes
□ Hearing loss or ringing	□ Lactose Intolerance	□ Hyperthyroidism (over active thyroid)
□ Earaches or drainage	□ H. Pylori	□ Pre-diabetic
□ Chronic sinus problems or rhinitis	□ Gastritis	**Dermatological**
□ Nose bleeds	□ Hiatal Hernia	□ Acne
□ Mouth Sores	**Genitourinary**	□ Basal Cell Carcinoma
□ Bleeding gums	□ BPH (benign prostatic hyperplasia)	□ Squamous Cell Carcinoma
Cardiovascular	□ Incontinence	□ Melanoma
□ Hypertension	□ Kidney Stones	□ Eczema
□ Angina	□ Interstitial Cystitis	□ Psoriasis
□ Swelling of hands, feet, ankles	□ Pelvic Inflammatory Disease (PID)	□ Uticaria (hives)
□ MI/heart attack	□ Urinary Tract Infection (UTI)	□ Rosacea
□ Heart rate irregularities	□ Dysmenorrhea (painful periods)	□ Cold Sores
□ Coronary artery disease	□ Sexually Transmitted Diseases	**Hematological and Lymphatic**
Respiratory	□ Erectile Dysfuntion	□ Anemia
□ Asthma	□ Prolapsed Bladder	□ Blood Clots
□ COPD	□ Menopause	□ Sickle Cell Disease
□ Chronic cough	□ Renal Failure	□ Lymphedema
□ Oxygen use	□ Hypogonadism (low hormones)	□ Lymphoma (Hodgekin's and Non-Hodgekins)
□ Hemoptysis (coughing up blood)	**Neurological**	**Autoimmune**
□ Tuberculosis	□ Epilepsy	□ Rheumatoid Arthritis
□ Pneumonia	□ Headaches or Migraines	□ Lupus
□ Bronchitis	□ Multiple Sclerosis	□ Inflammatory Bowel Disease
□ Sleep Apnea	□ Alzheimer's disease	□ Multiple Sclerosis
□ Pulmonary Hypertension	□ Traumatic Brain Injury (TBI)	□ Crohn's Disease
□ Pulmonary Fibrosis	□ Stroke	**Other:**
Musculoskeletal	□ Parkinson's Disease	□ Cancer:
□ Osteoarthritis	□ Postherpetic neuralgia	□ Aspirin/NSAID intolerance
□ Carpal Tunnel	**Psychiatric**	□ Hereditary disorders
□ Tendonitis	□ Depression	□ Other:
□ Back Pain	□ Anxiety	□ Other:
□ Herniated discs	□ PTSD	□ Other:
□ Myalgia (muscle pain)	□ Bipolar Disorder	□ Other:
□ Arthralgia (joint pain)	□ Eating Disorders	□ Other:
□ Fibromyalgia	□ Insomnia	□ Other:
□ Gout	□ Alcoholism	□ Other:
□ Cervicalgia (neck pain)	□ Substance Abuse	□ Other:

Notice 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.

Introduction

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We have created or will create a record of the care and services you receive at Advent Research. We need this record to provide you with quality care and comply with certain legal requirements. Accordingly, this Notice of Privacy Practices applies to all of the records of your care generated by Advent Research.

This Notice will also tell you the ways in which we may use and disclose medical information about you. It describes your rights and certain obligations we have regarding the use and disclosure of your protected health information.

Changes to this Notice

We reserve the right to make changes to this notice of privacy practices as allowed by law. If, and when, this notice of privacy practice changes, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised notice of privacy practices upon your request.

Acknowledgement

You will be asked to sign an acknowledgement to show that you have received this notice of privacy practices. Even if you do not sign the acknowledgement, we will still provide you with treatment.

Use and Disclosures

We will use and disclose elements of your protected health information (PHI) for treatment, payment (except as noted below) or health care operations without your consent or authorization. The examples included in each category do not list every type of use of disclosure that may fall within that category.

Without Your Signed Authorization

Treatment

We may use medical information about you to provide you with medical treatments or services. We may disclose medical information about you to doctors, nurses, technicians, institution or law enforcement official where necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

With Your Signed Authorization

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you may provide us.

Your Rights Regarding Your Medical Information

You have the following rights concerning your PHI:

Right to Access your Medical Records: You have the right to inspect and have copied medical information that may be used to make decisions about your care. You must submit any request to inspect or copy your medical information in writing. We may charge a fee for the cost of copying, mailing, or other supplies associated with your request.

We may deny your request in certain, very limited, circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Advent Research will review your

request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend your Medical Records: If you feel that medical information that we have about you is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as we keep that information. You must submit any request for amendment in writing. Your written request must provide a reason that supports your request.

We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our group;
- Is not part of the information which you are permitted to inspect and copy; or
- Is accurate and complete

Rights to an Accounting of Disclosures: You have the right to receive an accounting of the disclosures by us of your medical information for a period of six (6) years prior to your request. To do this, you must submit any request for an accounting of disclosures in writing. Your written request must state the time period, which may not be longer than six (6) years and may not include dates before March 6, 2007, when current federal health privacy laws became effective. The first report you request in a twelve (12) month period is free of charge. For any additional reports, we may charge for the cost of providing reports. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Rights to Request Restrictions: You have the right to request restricted access to all or part of your PHI. You have the right to request a restriction or limitation on the medical operations. You also have the right to request a limit on the medical information disclosed about you to someone who is involved in your care of the payment for your care, such as a family member or friend. This right to request restrictions is limited,

However, in that we are not required to agree to your request. If, however, we do agree to your request, we will comply with your request unless the information is needed to provide your emergency treatment. If you wish to request restrictions or limitations, you must do so in writing. Your written request must tell us what information you want to limit, whether to limit our use, disclosure, or both, and the identity of the person or persons you want limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must submit any request must tell us how or where you wish to be contacted. It is our policy to accommodate all reasonable requests.

Copy of this Notice: You may ask us to provide you with a copy of this Notice of Privacy Practices at any time. It is our policy to provide you with a copy at the first opportunity available to use.

Complaints: If you believe your privacy rights have been violated, you may complain to us or the U.S. Dept. of Health and Human Services.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this Notice of Privacy Practices:

Signature: _____Date:_____

Print name of patient:_____