MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form so we are able to provide the best care possible.

PATIENT NAME: (Print) Last First MI **TODAY'S DATE:**

BIRTHDATE: Mo. / Day / Yr. **Age:** **GENDER:** ☐ Male ☐ Female **I am:** ☐ Left Handed ☐ Right Handed

Primary Care Physician: Doctor who sent you here

DRUG ALLERGIES: ☐ No ☐ Yes If yes, list drug allergies and how you reacted:

List your current medications (presciption and over-the-counter medications, herbs, vitamins, etc):

Reason for visit today:

MEDICAL CONDITIONS: *Have you ever been diagnosed with any of the following?*

Diabetes	☐ Yes ☐ No	HIV	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
High Cholesterol or Lipids	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Psychiatric Illness/Phobias	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Blood Clots	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	DVTS	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Pulmonary Embolism	☐ Yes ☐ No

List any other medical illness(es):

List past surgeries:

FAMILY HEALTH HISTORY:

1) Bleeding	☐ Yes ☐ No	5) Bone Disease	☐ Yes ☐ No
2) Diabetes	☐ Yes ☐ No	6) Arthritis	☐ Yes ☐ No
3) High Blood Pressure	☐ Yes ☐ No	7) Cancer	☐ Yes ☐ No
4) Heart Disease	☐ Yes ☐ No	☐ Check if family history unknown	

Do any other illness(es) run in your family: *(See Reverse Side to complete)*

224407 (3/10)

Carolinas Medical Center

FACULTY PHYSICIAN NETWORK
MEDICAL HISTORY QUESTIONNAIRE

725

Patient Information or Sticker

Name:

DOB:

Medical Record #:

SOCIAL HISTORY: *(Check any that apply now or in the past)*

Alcohol Usage ☐ Yes ☐ No How Much? Quit Alcohol Usage: When?
Cigarette Smoking ☐ Yes ☐ No How Much? Quit Smoking: When?
Chewing Tobacco ☐ Yes ☐ No How Much? Quit Chewing Tobacco: When?
Exposure to Second-Hand Smoke: ☐ Yes ☐ No Current or Prior IV Drug Use: ☐ Yes ☐ No
Other Risk Factors for HIV: ☐ Yes ☐ No If yes, please explain:
Do you live alone? ☐ Yes ☐ No **Daycare?** ☐ Yes ☐ No Class Size:
Occupation:

Please check all symptoms which you have presently, or have had recently. If you have not experienced a medical problem under the SYMPTOM listed, check the "No" box.

GENERAL SYMPTOMS

☐ fever ☐ weight loss ☐ weight gain
other:
☐ No General Symptoms

EAR, NOSE & THROAT SYMPTOMS

Ear: ☐ hearing loss other:
Nose: ☐ obstruction other:
Throat: ☐ sore other:
☐ No Ear, Nose & Throat Symptoms

EYE SYMPTOMS

☐ blindness ☐ blurred vision
☐ double vision ☐ loss of vision
other:
☐ No Eye Symptoms

HEART SYMPTOMS

☐ chest pain ☐ irregular or rapid heartbeat
☐ leg cramps while walking
☐ blackout spells
☐ trouble breathing while lying flat
other:
☐ No Heart Symptoms

LUNG SYMPTOMS

☐ wheezing ☐ shortness of breath
other:
☐ No Lung Symptoms

GASTROINTESTINAL SYMPTOMS

☐ heartburn
other:
☐ No Gastrointestinal Symptoms

KIDNEY SYMPTOMS

☐ difficulty urinating ☐ frequent urination
other:
☐ No Kidney Symptoms

BONE, JOINT & MUSCLE SYMPTOMS

☐ joint pain ☐ joint swelling
other:
☐ No Bone, Joint or Muscle Symptoms

SKIN SYMPTOMS

☐ masses ☐ lesions
other:
☐ No Skin Symptoms

NERVOUS SYSTEM SYMPTOMS

☐ convulsions ☐ seizures
other:
☐ No Nervous Symptoms

BLOOD (HEMATOLOGIC) SYMPTOMS

☐ swollen lymph nodes ☐ bleeding tendency
☐ bruising without contact
other:
☐ No Blood (Hematologic) Symptoms

ENDOCRINE SYMPTOMS

☐ excessive thirst ☐ heat intolerance
☐ cold intolerance
other:
☐ No Endocrine Symptoms

ALLERGIES

☐ environmental allergies ☐ No environmental allergies

PSYCHIATRIC

☐ emotional disturbances
specify:
☐ No Psychiatric Illness

REVIEWED BY:

M.D. DATE: / /

Patient Information or Sticker

Carolinas Medical Center

FACULTY PHYSICIAN NETWORK
MEDICAL HISTORY QUESTIONNAIRE

Name:

DOB:

Medical Record #:

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Hospital maintains personnel and facilities to assist my physicians in providing me medical care, and I authorize the Hospital personnel to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Hospital and its personnel are not responsible for providing me this information. I choose to receive the services even if my insurance plan may not cover or continue to cover specific services, including the specific services rendered during the admission.

ASSIGNMENT OF INSURANCE BENEFITS. I we hereby assign all my rights to The Charlotte Mecklenburg Hospital Authority ("CHS") under any policy of insurance, including but not limited to, major medical insurance, hospital benefits, sick benefits, injury benefits due to me because of liability of a third party, such as auto insurance or Workers Compensation insurance, and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient up to the full amount of the hospital bill, and hereby authorize direct payment to Carolinas Medical Center and or my attending physicians of all benefits to which I am entitled. This assignment includes payment of hospital, surgical, and medical benefits to the Charlotte Radiological Group, P.A., Southeast Anesthesia Associates, P.A., Charlotte Pathology Group, P.A., Southeast Radiation Oncology Group, P.A., The Charlotte-Mecklenburg Health Services Foundation, Inc., and Piedmont Emergency Medicine Associates or any other professional groups contracted by CHS for professional services they may perform for me. In addition, I we further warrant and represent that any insurance which I we assign is valid insurance and in effect and that I we have the right to make this assignment. I understand that I am financially responsible to the Hospital, my physicians, and those entities named in this assignment for amounts due that are not covered by this assignment. For example, I know that sometimes insurance companies will not pay for services ordered by my physician and which I have authorized. I understand that these payment denials occur for a variety of reasons. My insurance policy may not include the particular service as a benefit. In other cases, a service will not be covered by my insurance company because it decides the service is not necessary, despite my physician's decision to order the service. In any event, even if a service is not covered by insurance, I agree to pay for all charges for all services rendered, including the specific services rendered during this admission. I further agree that in the event benefits paid under this assignment or any other amounts paid by me us or in my our behalf exceed the amounts due the Hospital, my physicians, or those entities for services in connection with this hospitalization, any such excess amount may be applied to any other indebtedness that I or my spouse or any child for whom I am financially responsible may have to the Hospital or any other facility or entity related to CHS, my physicians, or these other entities.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION. I authorize the Hospital and my physicians to furnish any medical information relating to my hospitalization or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my hospital and medical care. I also authorize the Hospital and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred to transferred for further medical care. In addition, I authorize the Hospital and my physician to release any medical information necessary to prove the Hospital's damages in any legal proceeding brought to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or y legal representative may revoke this authorization at any time, except to the extent that: (i) action has already been taken, or (ii) in the event of my death, the release of medical information is necessary to verify any charges incurred by me.

AUTHORIZATION TO RELEASE MEDICARE AND MEDICAID INFORMATION. I certify that the information provided by me in applying for payment under Titles V, XVIII and or XIX of the Social Security Act is correct. I understand that health care services paid for under the Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued hospital care. I authorize those agencies responsible for determining eligibility under these programs to provide to the Hospital any information relating to the determination of my eligibility. I request payment of benefits under these programs be made to the Hospital and my physicians on my behalf.

PAYMENT GUARANTY. I (patient and/or responsible party ies) agree to pay all charges for services rendered by the Hospital and my physicians or other providers during my hospitalization or treatment. This guaranty includes charges for services not covered by my insurance, regardless of the reason that insurance coverage is denied. If I fail to pay all charges and the Hospital or my physicians use an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges.

PERSONAL PROPERTY. The Hospital will hold any money, valuables or other personal property in my possession until I am able to return them home for safekeeping. I understand the Hospital is not responsible for money, valuables and other personal property retained in my room and has no liability for their loss.

RELEASE OF INFORMATION. I authorize the Financial Counseling staff of the Hospital to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the

Patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. I request that if my benefits are approved or denied, a copy of the approval or denial be attached and returned with the referral form. The doctrine of informed consent has been explained to me. I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization or until final determination of any benefits application as described above, whichever is later.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. Witness my (our) hand(s) and seal(s) below.

Patient (Seal)

Witness

Date Time

Responsible Party ies (Seal)

Relation to Patient:

Husband
Parent s
Wife
Other (Specify)

Policyholder (if other than patient)

AUTHORIZATIONS AND REFERRALS. To avoid decreased insurance benefits, you are advised to check with your primary care physician or insurance company prior to services being rendered. If your insurance plan requires an authorization or referral, it is your responsibility to ensure this has been completed. You may have to contact your primary care physician or your insurance company directly to arrange for an authorization or referral.

DIAGNOSTIC TESTS. If the doctor sends you to have a diagnostic test (e.g., MRI, CT scan, etc.), you may receive a bill for the actual test and a separate bill for the interpretation of the test. Please consult your insurance company for questions about your deductible and co-payments.

IN-OFFICE X-RAYS. The X-ray machine in this office is owned and operated by Carolinas Medical Center. **Charges for x-rays are billed as "hospital outpatient services".** Your insurance may or may not have higher deductibles for services billed in this manner. Please consult your insurance company if you have concerns about your deductible. You will receive one bill from our system billing office for your x-rays and a separate bill from Charlotte Radiology for x-ray interpretation.

MEDICAL EQUIPMENT AND SUPPLIES. Medical devices and supplies given out in our office may be supplied by a third party vendor and are billed separately to you or your insurer by their office.

☐ I have been provided access to CHS's Notice of Privacy Practices

Signature Date Time
(Patient or Authorized Representative)

Relationship to Patient Reason Patient Unable/Unwilling to sign

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Carolinas HealthCare System

REQUEST FOR TREATMENT AND AUTHORIZATION

PATIENT IDENTIFIER

Attachment A
PR.PHI 140.05

One Patient Per Authorization Form

There may be a charge for record copies

Carolinas HealthCare System - Authorization for Release of Health Information Form

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations once it is disclosed.

PURPOSE OF RELEASE: ❑Ongoing Communication ❑Copy of Record ❑Legal or Insurance Review ❑Authorized Representative's Request ❑ Other _____

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:
Facility/Practice Name: _____ **Telephone #:** _____
Facility/Practice Address: _____ **Fax #** _____

DATES OF SERVICE, RANGE OF TIME OR EVENT(S) The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s):
From: (MM/DD/YY) _____ To: (MM/DD/YY) _____
This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details** ❑ **Other (Please Specify)** _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____
First Middle Maiden Last

Patient Address: _____
(Street Address/PO Box, City, State, Zip)

Social Security #: _____ **Date of Birth:** _____ **Medical Record/Chart #** _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

Please provide email address where you are authorizing CHS to leave patient information as described above. By providing your email address you agree that you have read and agree to the "Guidelines for email with patients" posted on www.carolinashealthcare.org
Email Address: _____

RELEASE TO This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.

I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.

I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____
SIGNATURE: _____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

NAME OF MINOR: _____ **SIGNATURE OF MINOR:** _____ **DATE:** _____

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N/A ❑ Identification verified ❑ Copy of Authorization given to patient / Date of release: _____ via ❑Mail ❑Fax ❑Other _____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

CHS Employee Name & Title: _____ **CHS Employee Signature:** _____ **Date** _____ **Rev. 09/17/08**

CMC ORTHOPAEDICS
PATIENT'S PHYSICIAN INFORMATION

Patient's Name: _____
(First) (M.I.) (Last)

1. Primary Care Physician: _____
(First) (M.I.) (Last)

   Practice Name: _____

   Practice Address: _____

   City/State: _____

   Phone #: _____ Fax #: _____

2. Referring Physician: _____
(First) (M.I.) (Last)

   Practice Name: _____

   Practice Address: _____

   City/State: _____

   Phone #: _____ Fax #: _____

3. Specialist Physician: _____
(First) (M.I.) (Last)

   Practice Name: _____

   Practice Address: _____

   City/State: _____

   Phone #: _____ Fax #: _____

4. Other Physician: _____
(First) (M.I.) (Last)

   Practice Name: _____

   Practice Address: _____

   City/State: _____

   Phone #: _____ Fax #: _____

Carolinas Medical Center

CMC Orthopaedics
PATIENT'S PHYSICIAN INFORMATION

Patient Information or Sticker

Name:

DOB:

Medical Record #: