# Vivian O. Rodriguez M.D., P.A.

NAME ______________________________ SS# ________________

________________ ________________ ________________
MARITAL STATUS DATE OF BIRTH REFERRED BY

LOCAL ADDRESS ________________ CITY __________ STATE ______ ZIPCODE ________

EMAIL ______________________________________________

HOME PHONE ____________ CELL PHONE ____________ OTHER ____________

NAME OF EMPLOYER ______________________ OCCUPATION ____________

EMPLOYER ADDRESS ______________________ PHONE ____________

SPOUSE'S NAME ________________ DATE OF BIRTH ____________ SS# ____________

SPOUSE'S EMPLOYER ______________________ PHONE ____________

________________ ________________ ________________ ________________
NEAREST RELATIVE NOT LIVING WITH YOU PHONE DENTIST PHONE

________________ ________________ ________________
CONTACT IN CASE OF EMERGENCY RELATION PHONE

______________________________________________
FAMILY PHYCISIAN OR INTERNIST ADDRESS PHONE

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? ______________________
(THIS DOES NOT INCLUDE YOUR INSURANCE OR ANOTHER THIRD PARTY PAYOR)

________________ ________________ ________________
WHAT IS YOUR PRIMARY INSURANCE? INSURED'S NAME INSURED'S DATE OF BIRTH

________________ ________________ ________________
RELATIONSHIP TO PATIENT INSURED'S ID# INS. GROUP NUMBER

________________ ________________ ________________
WHAT IS YOUR SECONDARY INSURANCE? INSURED'S NAME INS.GROUP NUMBER

________________ ________________ ________________
RELATIONSHIP TO PATIENT INSURED'S ID# INSURED'S DATE OF BIRTH

IS YOUR CONDITION RELATED TO:

| | | |
|---|---|---|
| EMPLOYMENT (current or previous) | YES | NO |
| AUTO ACCIDENT | YES | NO |
| OTHER ACCIDENT | YES | NO |

THE INFORMATION I HAVE PROVIDED IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

SIGN: ______________________________ DATE ______________________

## New Patient Information Form

| Date | **Document at Least 3** |
|---|---|
| Patient | Sitting BP____/____ Height ________ |
| Referred by | Standing BP____/____ Weight ________ |
| | Supine BP____/____ Temp.________ |
| | Heart rate ______ Resp. rate______ |

### History

| **Chief Complaint/History of Present Illness** | For an "Extended" History, Document 4+ Elements |
|---|---|

- Location (Where is the pain/problem?)
- Severity (How severe is the pain/problem?)
- Timing (Does this pain/problem occur at a specific time?)
- Associated signs/symptoms
- Quality (Example: color of sputum)
- Duration (How long have you had this pain/problem? or When did it start?)
- Context (Where were you at the onset of this pain/problem?)
- Modifying (What makes the pain/problem worse or better? or Any previous episodes?)

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

| **Medical History** | **For a "Pertinent" History,** at Least 1 Specific Item for ANY ONE of the 3 Histories | **For a "Complete" History,** at Least 1 Specific Item for EACH ONE of the 3 Histories |
|---|---|---|

- **Patient Medical History**

| | | |
|---|---|---|
| Diabetes | ☐ No | ☐ Yes |
| Hypertension | ☐ No | ☐ Yes |
| Cancer | ☐ No | ☐ Yes |
| Stroke | ☐ No | ☐ Yes |
| Heart trouble | ☐ No | ☐ Yes |
| Arthritis/gout | ☐ No | ☐ Yes |
| Convulsions | ☐ No | ☐ Yes |
| Bleeding tendency | ☐ No | ☐ Yes |
| Acute infections | ☐ No | ☐ Yes |
| Venereal disease | ☐ No | ☐ Yes |
| Hereditary defects | ☐ No | ☐ Yes |

| Previous Hospitalizations/Surgeries/Serious Injuries | When? |
|---|---|
| | |
| | |
| | |
| | |

- **Family Medical History**

| | |
|---|---|
| | |
| | |
| | |
| | |

- **Patient Social History**

| | | | | | |
|---|---|---|---|---|---|
| Marital status: | ☐ Single | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed |
| Use of alcohol: | ☐ Never | ☐ Rarely | ☐ Moderate | ☐ Daily | |
| Use of tobacco: | ☐ Never | ☐ Previously, but quit | Current packs/day ______ | | |
| Use of drugs: | ☐ Never | Type/Frequency | | | |

- **Medications**

| | |
|---|---|
| 1) ______________________ | 7) ______________________ |
| 2) ______________________ | 8) ______________________ |
| 3) ______________________ | 9) ______________________ |
| 4) ______________________ | 10) ______________________ |
| 5) ______________________ | 11) ______________________ |
| 6) ______________________ | 12) ______________________ |

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## Review of Systems

### For an "EXTENDED" System Review at Least 2 Systems

- **Constitutional Symptoms**
  - Good general health lately ☐ No ☐ Yes
  - Recent weight change ☐ No ☐ Yes
  - Fever ☐ No ☐ Yes
  - Fatigue ☐ No ☐ Yes
  - Headaches ☐ No ☐ Yes
- **Eyes**
  - Eye disease or injury ☐ No ☐ Yes
  - Wear glasses/contact lens ☐ No ☐ Yes
  - Blurred or double vision ☐ No ☐ Yes
  - Glaucoma ☐ No ☐ Yes
- **Ears/Nose/Mouth/Throat**
  - Hearing loss or ringing ☐ No ☐ Yes
  - Earaches or drainage ☐ No ☐ Yes
  - Chronic sinus problem or rhinitis ☐ No ☐ Yes
  - Nose bleeds ☐ No ☐ Yes
  - Mouth sores ☐ No ☐ Yes
  - Bleeding gums ☐ No ☐ Yes
  - Bad breath or bad taste ☐ No ☐ Yes
  - Sore throat or voice change ☐ No ☐ Yes
  - Swollen glands in neck ☐ No ☐ Yes
- **Cardiovascular**
  - Heart trouble ☐ No ☐ Yes
  - Chest pain or angina pectoris ☐ No ☐ Yes
  - Palpitation ☐ No ☐ Yes
  - Shortness of breath with walking or lying flat ☐ No ☐ Yes
  - Swelling of feet, ankles or hands ☐ No ☐ Yes
- **Respiratory**
  - Chronic or frequent coughs ☐ No ☐ Yes
  - Spitting up blood ☐ No ☐ Yes
  - Shortness of breath ☐ No ☐ Yes
  - Asthma or wheezing ☐ No ☐ Yes
- **Gastrointestinal**
  - Loss of appetite ☐ No ☐ Yes
  - Change in bowel movements ☐ No ☐ Yes
  - Nausea or vomiting ☐ No ☐ Yes
  - Frequent diarrhea ☐ No ☐ Yes
  - Painful bowel movements or constipation ☐ No ☐ Yes
  - Rectal bleeding or blood in stool ☐ No ☐ Yes
  - Abdominal pain or heartburn ☐ No ☐ Yes
  - Peptic ulcer (stomach or duodenal) ☐ No ☐ Yes
- **Genitourinary**
  - Frequent urination ☐ No ☐ Yes
  - Burning or painful urination ☐ No ☐ Yes
  - Blood in urine ☐ No ☐ Yes
  - Change in force of strain when urinating ☐ No ☐ Yes
  - Incontinence or dribbling ☐ No ☐ Yes
  - Kidney stones ☐ No ☐ Yes
  - Sexual difficulty ☐ No ☐ Yes
  - Male–testicle pain ☐ No ☐ Yes
  - Female–pain with periods ☐ No ☐ Yes
  - Female–irregular periods ☐ No ☐ Yes
  - Female–vaginal discharge ☐ No ☐ Yes
  - Female–# pregnancies _____ # miscarriages_____
  - Female–date of last pap smear_____/_____/_____
  - Female–age of menarche _____
  - Female–age of first pregnancy _____
  - Female–last menstrual period _____/_____/_____

### For a "COMPLETE" System Review–At Least 10 Systems
(Dictate responses to pert. systems, then "All other systems negative").

- **Musculoskeletal**
  - Joint pain ☐ No ☐ Yes
  - Joint stiffness or swelling ☐ No ☐ Yes
  - Weakness of muscles or joints ☐ No ☐ Yes
  - Muscle pain or cramps ☐ No ☐ Yes
  - Back pain ☐ No ☐ Yes
  - Cold extremities ☐ No ☐ Yes
  - Difficulty in walking ☐ No ☐ Yes
- **Integumentary (Skin, Breast)**
  - Rash or itching ☐ No ☐ Yes
  - Change in skin color ☐ No ☐ Yes
  - Change in hair or nails ☐ No ☐ Yes
  - Varicose veins ☐ No ☐ Yes
  - Breast pain ☐ No ☐ Yes
  - Breast lump ☐ No ☐ Yes
  - Breast discharge ☐ No ☐ Yes
- **Neurological**
  - Frequent or recurring headaches ☐ No ☐ Yes
  - Light headed or dizzy ☐ No ☐ Yes
  - Convulsions or seizures ☐ No ☐ Yes
  - Numbness or tingling sensations ☐ No ☐ Yes
  - Tremors ☐ No ☐ Yes
  - Paralysis ☐ No ☐ Yes
  - Stroke ☐ No ☐ Yes
  - Head injury ☐ No ☐ Yes
- **Psychiatric**
  - Memory loss or confusion ☐ No ☐ Yes
  - Nervousness ☐ No ☐ Yes
  - Depression ☐ No ☐ Yes
  - Insomnia ☐ No ☐ Yes
- **Endocrine**
  - Glandular or hormone problem ☐ No ☐ Yes
  - Thyroid disease ☐ No ☐ Yes
  - Diabetes ☐ No ☐ Yes
  - Excessive thirst or urination ☐ No ☐ Yes
  - Heat or cold intolerance ☐ No ☐ Yes
  - Skin becoming dryer ☐ No ☐ Yes
  - Change in hat or glove size ☐ No ☐ Yes
- **Hematologic/Lymphatic**
  - Slow to heal after cuts
  - Bleeding or bruising tendency
  - Anemia
  - Phlebitis
  - Past transfusion
  - Enlarged glands ☐ No ☐ Yes
- **Allergic/Immunologic**
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics ☐ No ☐ Yes
    - Morphine, Demerol, or other narcotics ☐ No ☐ Yes
    - Novocaine or other anesthetics ☐ No ☐ Yes
    - Aspirin or other pain remedies ☐ No ☐ Yes
    - Tetanus antitoxin or other serums ☐ No ☐ Yes
    - Iodine, methiolate or other antiseptic ☐ No ☐ Yes

Other drugs/medications _______________

Known food allergies _______________

Additional Comments _______________

Physician _______________ Date _______________

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# *FAMILY AND FRIENDS CONTACT FORM*

*We strongly recommend that you consistently bring a family member or friend with you to your appointments. We ask that you bring no more than a maximum of two persons at each visit.*

**Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with.** (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

***Please list those persons (including family, friends, your family doctor (PCP), and other doctors/specialists) with whom we may share your information:***

| | |
|---|---|
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |

***What is the BEST phone number for us to contact you?***

**Phone Number:** ______________________________

What is this number (Home, Work, Cell, Other)? ______________________________

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include details (such as diagnosis and medication information) at this number?** ____________

***What other ways may we contact you? Please list any that are acceptable ways to reach you.***

**Home Phone Number:** ______________________________

Is it OK to leave a **detailed** message at this number in your absence? ____________

**Work Number:** ______________________________

Is it OK to leave a **detailed** message at this number in your absence? ____________

**Cell Phone Number:** ______________________________

Is it OK to leave a **detailed** message at this number in your absence? ____________

**Other:** ______________________________

Is it OK to leave a **detailed** message at this number in your absence? ____________

______________________________ ____________
**Signature of Patient or Legal Representative** **Date**

______________________________ ____________
**Print name of Patient or Legal Representative** **Relationship to Patient**

## ***ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES***

Vivian O. Rodriguez M.D.P.A.

I, ______________________________________________ (print name), acknowledge and agree that I have reviewed a copy of the Vivian O. Rodriguez M.D.P.A. . Notice of Privacy Practices.

I also understand that an electronic copy of this and other documents requiring my signature will be accepted as an original.

______________________________________________ ________________________

Signature of Patient or Patient's Legal Representative Date

______________________________________________ ________________________

Print Name of Legal Representative Relationship to patient

## ***CLINIC USE ONLY:***

If written acknowledgement of the Notice of Privacy Practices was not obtained, please document the effort(s) made in good faith and the reason(s) why such acknowledgement was obtained.

Clinic Name: ______________________________________________

Name of Patient: ______________________________________________

Efforts made to obtain Acknowledgement: ______________________________

______________________________________________

______________________________________________

Reasons why Acknowledgement was not obtained: ________________________

______________________________________________

______________________________________________

______________________________________________ ________________________

Signature of Employee Date

______________________________________________ ________________________

Print Name of Employee Title