PRO HEALTH & REHAB CLINIC

2453 Powder Springs Rd. Suite.210-215● Marietta, GA 30064●T 678-567-2313● F 855-771-9101

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Patient Information

Name_____ Today's Date_____
Date of Birth_____ □Male □Female **Phone Numbers:**
SSN:_____ Home:_____
Address:_____ Cell: _____
City:_____ State:_____ Zip Code:_____ *__E-MAIL__ **for Reminders of Future Appointments:**
If under 18 years old, Guardian's Name: _____ _____
Consent to treat a minor- Signature:_____ **Emergency Contact:** _____
Spouse\Significant Other _____ Relation: _____
Spouse's birthdate:_____ Spouse Occupation:_____ Phone #: _____

SOCIAL HISTORY:

Birthplace_____ Your Occupation _____
Nationality _____ Work Name and Address: _____
Religion _____ _____
Drug Use_____ Education_____
Tobacco Use □Yes □No Type_____ Marital Status_____ How many years_____
Packs per day____ for____ years Quit_____ Children_____
Alcohol Use □Yes □No Type_____ _____
Drinks: _____ per □day □week □month Pets_____
If heavy use, how many years_____ Quit_____ Exercise (type/how often?) _____
Caffeine (coffee, tea, soda, chocolate) Servings per day_____ Recent or Frequent Travel Destinations _____
_____

ALLERGIC And Adverse Reactions to Medications:

Name of Medication: Adverse Reaction:

_____
_____
_____
_____

MEDICATIONS: Name, Dosage, Strength, and Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Preferred Pharmacy: _____ **Pharmacy Phone Number:** _____

*Patient's with Humana HMOx: Your insurance only covers CVS and Walmart pharmacies.

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ Cancer Type:_____
- ☐ Heart Attack/Coronary
- ☐ Artery Disease
- ☐ Rheumatic Fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn / Reflux
- ☐ Asthma
- ☐ Seizures
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent Bladder Infection
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Polio
- ☐ Chicken Pox
- ☐ Infectious Mono
- ☐ Anemia
- ☐ Frequent Sinus Infections
- ☐ Glaucoma
- ☐ Thyroid Trouble
- ☐ Hives
- ☐ Depression
- ☐ Head Injury _____
- ☐ Broken Bones
- ☐ Blood transfusions
- ☐ Sexually Transmitted Diseases: Herpes, Gonorrhea, HIV, Chlamydia, or Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate Enlargement
- ☐ Cystic Fibrosis
- ☐ Malaria
- ☐ Other_____

IMMUNIZATIONS:

- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Chicken pox vaccine
- ☐ Hepatitis B vaccine
- ☐ Influenza vaccine
- ☐ Pneumococcal vaccine
- ☐ Tetanus booster

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

- ☐Eyes (Laser or Vision Corrected) ____
- ☐Eyes (Cataract/Glaucoma) ____
- ☐Ears ____
- ☐Sinus/Nasal Septum ____
- ☐Tonsils/Adenoid ____
- ☐Thyroid ____
- ☐Heart ____
- ☐Stomach ____
- ☐Gall Bladder _____
- ☐Appendix _____
- ☐Intestine/Colon _____
- ☐Hemorrhoids _____
- ☐Hernia _____
- ☐Breast _____
- ☐Uterus/Hysterectomy _____
- ☐Ovaries _____
- ☐Spinal Surgery/Neck _____
- ☐Spinal Surgery/Back _____
- ☐Orthopedic: (Hips/ Knee Shoulder/ Feet/Hands) ____
- ☐C-section _____
- ☐Vasectomy _____
- ☐Tubal Ligation _____
- ☐Prostate _____
- ☐Varicose Veins ____
- ☐OTHER _____

Previous Health Care Providers In The Past Five Years:

Name	Phone/Fax number	Problem Cared For:	Still Seeing?	Referral?
			Yes/No	**Yes/No**
			Yes/No	**Yes/No**
			Yes/No	**Yes/No**
			Yes/No	**Yes/No**

Has anyone in your FAMILY ever had? **(If yes check box and list relationship)**

- ☐Cancer & Type _____
- ☐Diabetes _____
- ☐Cardiac Dysrhymthia _____
- ☐Congestive Heart Failure_____
- ☐Coronary Artery Disease_____
- ☐Valvular heart Disease _____
- ☐High Blood Pressure _____
- ☐High Cholesterol _____
- ☐Stroke _____
- ☐Kidney stones _____
- ☐Kidney disease _____
- ☐Dialysis _____
- ☐Chronic lung disease _____
- ☐Tuberculosis _____
- ☐Rheumatoid Arthritis _____
- ☐Thyroid trouble _____
- ☐Osteoporosis _____
- ☐Cystic Fibrosis _____
- ☐Asthma _____
- ☐Peptic Ulcer _____
- ☐Gallstones _____
- ☐OTHER _____
- ☐Crohn's/colitis _____
- ☐Alzheimer's _____
- ☐Alcoholism _____
- ☐Bleeding tendency _____
- ☐Anemia _____
- ☐Gout _____
- ☐Depression _____
- ☐Mental illness _____
- ☐Seizures _____
- ☐Migraine headaches _____

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Age when you Started Menstruating? _____ Number of Pregnancies? _____

Date of Last PAP? _____ Number of Births? _____

History of abnormal Pap's: Yes / No (Please circle) Vaginal / C-section (Please Circle)

Date of Last Mammogram? _____ Method of Contraception _____

History of Abnormal Mammograms Yes / No (Please circle)

Menstrual Cycles? Regular / Irregular (Please Circle) Pain with Periods? Yes / No (Please Circle)

Age at Menopause? _____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- □Fatigue
- □Fever
- □Weight Gain >10 pounds
- □Weight Loss >10 pounds

SKIN
- □Nail Changes
- □New Lesions
- □Rash
- □Skin Color Changes

HEENT
- □Double Vision
- □Eye Pain
- □Eye Redness
- □Decreased Hearing
- □Earache
- □Ear Ringing
- □Nose Bleeds
- □Dry Mouth
- □Hoarseness
- □Oral Ulcers
- □Sore Throat

NECK
- □Neck Pain
- □Swollen Glands

RESPIRATORY
- □Chronic Cough
- □Decreased Exercise Tolerance
- □Difficulty Breathing
- □Coughing Up Blood
- □Sputum Production
- □Wheezing

BREAST
- □Breast Mass
- □Breast Pain
- □Nipple Discharge
- □Skin Changes

CARDIOVASCULAR
- □Chest Pain
- □Leg Pains with walking
- □Leg Swelling
- □Night Awakening due to trouble Breathing
- □Palpitations
- □Shortness of Breath

GASTROINTESTINAL
- □Abdominal Pain
- □Change in Bowel Habits
- □Constipation
- □Diarrhea
- □Nausea
- □Vomiting
- □Rectal Bleeding
- □Trouble Swallowing

GENITOURINARY
- □Vaginal Discharge
- □Menstrual Irregularities
- □Difficulty Starting/Stopping urinary Stream
- □Painful Urination
- □Change in Urinary Stream
- □Increased Frequency
- □Blood in Urine
- □Loss of Bladder Control
- □Nighttime Urination
- □Urinary Retention
- □Urethral Discharge
- □Impotence
- □ Penile Lesions
- □Testicular Mass
- □Testicular Pain
- □Appetite Changes
- □Cold Intolerance

MUSCULOSKELETAL
- □Decreased Range of Motion
- □Joint Pain
- □Joint Redness
- □Joint Swelling
- □Joint Stiffness
- □Muscle Wasting
- □Muscle Weakness
- □Muscle Aches/Pains

NEUROLOGICAL
- □Loss of Bowel Control
- □ Dizziness/Vertigo
- □Headaches
- □Numbness/Tingling
- □Passing Out
- □Seizures
- □Tremor

PSYCHIATRIC
- □Anxiety
- □Change in Sleep Pattern
- □Depression
- □Hallucinations
- □Suicidal Thoughts

ENDOCRINE
- □Increased Thirst
- □Increased Urination
- □Hair Changes
- □Sexual Dysfunction

HEMATOLOGY
- □Easy Bruising
- □Enlarged Lymph Nodes
- □Prolonged Bleeding

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____ Reviewed By:_____

Assignment And Release:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that fees for services at this office are due and payable at the time of service authorize payment from any benefits carrier be made directly to Pro Health & Rehab with the understanding that all moneys will be credited to my account upon receipt. I clearly understand and agree that all services be rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. **Lastly, I understand there will be a $25 missed appointment fee if I do not call to cancel or reschedule my appointment within 24 hours of the scheduled time.**

Patient's Signature: _____ Date: _____

PRO HEALTH AND REHAB
2453 Powder Springs Rd. S-210
Marietta, Ga. 30064
Office: 678-567-2313 Fax:855-771 -9101

AUTHORIZATION, ASSIGNMENT, AND RELEASE FORM

Patient Printed Name: _____ DOB: _____

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges I incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and /or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amount you do not collect from the insurance companies' proceeds, whether it is all part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I hereby waive the stature of limitations on collection and/or recovery in this State of Georgia.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. You are authorized to release confidential information which may include substance abuse, behavioral health, HIV and/or AIDS.

7. This Authorization and Assignment will be in continual effect until revoked by both parties.

Date _____ Patient Signature_____

RECORDS RELEASE

To _____, I hereby authorize you to release to _____

any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____to _____.

_____ _____ _____ _____

Date Patient/ Insured Signature Date Staff Signature

PRO HEALTH & REHAB AUTHORIZATION FORM
PRIVACY NOTICE

THE PATIENT IDENTIFIED BELOW AUTHORIZES **Pro Health & Rehab** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to **Pro Health & Rehab** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, monthly newsletters, holiday related cards, information about treatment alternatives or other health related information.

If **Pro Health & Rehab** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give **Pro Health & Rehab** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving **Pro Health & Rehab** permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Pro Health & Rehab**. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and Your signature.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION,

Pro Health & Rehab will not refuse to provide treatment.

Print Name of Patient _____

Signature of Patient _____

Date _____

Authorized by_____