Medical History Form

Date:__________________

Name:____ DOB:_____________________

Sex: ☐Male ☐Female Height: ________________ Weight: ___________________

Primary Care Physician:____
Cardiologist:____
Other physicians:____

REASON FOR VISIT:____

SOCIAL HISTORY:

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged ☐ Partner

Are you in a nursing home or assisted living? ☐ No ☐ Yes ____________________________
Do you live alone? ☐ No ☐ Yes If no, who do you live with?______________________________
If yes do you have a caretaker? ☐ No ☐ Yes Who? __________________________________

Do you work? ☐ No ☐ Yes ☐ Retired ☐ Disabled Where do you work? _______________________
If yes what is your job Description? ____

Tobacco Use
☐ Never ☐ Quit Date__________ ☐ Current Smoker: _______packs/day_______ # of years smoking
☐Cigarettes ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use Do you drink alcohol? ☐ No ☐ Yes # drinks_________per day/month

Do you require the use of a mobility device?
☐Wheelchair ☐Walker ☐Cane ☐Stretcher ☐Other _________________________________

Are you Left Handed or Right Handed? ☐ Left ☐ Right

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Do you have any allergies to food or medicine? ☐ No ☐ Yes

If yes, then list them below:

Medication/Food	Reaction	Medication/Food	Reaction

SURGICAL HISTORY:

Surgery/Procedure	Date	Surgery/Procedure	Date

PAST MEDICAL HISTORY:

VASCULAR
 Varicose Veins Spider Veins Blood Clot Leg/Arm Pulmonary Embolism (blood clot in lung)
 Phlebitis Lymphedema Arms/Legs Leg Swelling Worn Compression Hose
Aneurysm Abdominal/Thoracic Renal Artery Stenosis Mesenteric Ischemia
 Stroke(CVA) When?_______ Mini Stroke(TIA) When?_________
 Amputation of fingers/toes/legs Prosthetic Where?_____________________
 Pain in legs when walking How far can you walk? _____ feet/blocks/miles

RESPIRATORY
Cough/Wheezing COPD Asthma Emphysema Tuberculosis

NEUROLOGICAL
 Headaches Migraines Dizziness Seizure Disorder Tremors
 Alzheimer's Dementia Peripheral Neuropathy Epilepsy Parkinson's

EYES/ EAR/NOSE/THROAT/SKIN
 Change in Vision Glaucoma Glasses/Contacts Difficulty hearing Seasonal Allergies
 Loss Of Vision Blurred Vision Cataracts Bruising Redness on legs/feet Hardened Skin

CARDIOVASCULAR
 High Blood Pressure High Cholesterol/Lipids Low Blood Pressure PFO (hole in heart)
 Congestive Heart Failure Mitral Valve Prolapse Coronary Artery Disease Heart Attack
Heart Murmur Heart Bypass Atrial Fibrillation Pace Maker Defibrillator

MUSCULO-SKELETAL
 Chronic Back Pain Arthritis Joint Pain Osteoporosis

GASTROINTESTINAL/GENITOURINARY
Stomach pain after eating Loss Of Appetite Acid Reflux/GERD
 Kidney Stones Prostate Problems Irritable Bowel Syndrome
 Crohn's Stomach Ulcers

NEPHROLOGY
 Renal Failure Do you have an AV Fistula/Graft? __________________
Any recent procedures on AV Fistula/Graft? ____________________________
Where? _____________________ AV Fistula/Graft: Left Arm/Right Arm
Do you have any other failed AV Fistulas/Grafts? ______________________
Dialysis Location: Davita/Fersenius Where? _______________________
Days: Monday Wednesday Friday Tuesday Thursday Saturday

ENDOCRINE/HEMATOLOGY
 Hepatitis Type A B C Liver Cirrhosis Diabetes HIV/AIDS Anemia
 Hypothyroid Hyperthyroid Gout Goiter
 Cancer Body Part: _________________________________ Chemotherapy Radiation

PHYSCHIATRIC
 Anxiety Schizophrenia Insomnia Depression Bipolar Disorder Suicidal Thoughts

MEDICATION LIST

Patient Name: ____DOB: ______________

Name of Mail Order Pharmacy: ____

Name of Local Pharmacy: ____
Pharmacy Location: ____
Pharmacy Phone Number: ____

Please list ALL known prescriptions, over-the-counter medications, and vitamin/herbal supplements below

NAME OF MEDICATION	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

PATIENT INFORMATION

PATIENT NAME:_________________________________ DATE:_____________________

ADDRESS:____

CITY:___________________________ STATE:_______ ZIPCODE:____________________

HOME PHONE:_________________________ CELL PHONE:________________________

DOB:___________________ AGE:__________ SS#_______________________________

*EMAIL ADDRESS:____

EMPLOYER:_______________________________ OCCUPATION:__________________

ADDRESS:____

CITY:________________________________ STATE:______ ZIP CODE:______________

PHONE #:_________________________ CALLS ALLOWED:_____Y______N

PRIMARY INSURANCE:____

SECONDARY INSURANCE:____

IF SPOUSE IS INSURED'S SPONSOR

NAME OF SPONSOR:______________________________ DOB:___________________

SS#_____________________________________

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT:_____SELF ____SPOUSE _____PARENT

____GUARDIAN ____POWER OF ATTORNEY

NAME:_____________________________________ PHONE#_____________________

ADDRESS_________________________ DOB:___________ SS#__________________

STATE:______ ZIP CODE:__________

Patrick M. Tamim, M.D.
Board Certified Vascular Surgeon
221 East 23rd Street Suite E Panama, City Florida 32405
3871 East Highway 98 Suite 202 Port St Joe, Florida 32456
Phone: 850-215-9654 Fax: 850-215-6934

Authorization for Release of Information:

I hereby authorize the use of disclosure of my health information as described below. I understand authorization is voluntary and I may refuse to sign. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Please disclose complete health record, radiology reports, office notes, diagnostic exams, and recent laboratory test to 850-215-6934. This authorization will expire 12 months from date of signature.

Patient Name___________________________________Date of Birth________________
Patient Signature________________________________Date of Signature____________

If patient is unable to sign, below is the name and signature of the patient's legal representative.

Relationship to Patient:___________________________Date of Signature____________
Legal Representative Name:____
Legal Representative Signature:____

HIPPA Release
The following list of family members/caretakers may receive verbal information in regards to my health care.

Power Of Attorney/Legal Guardian
Name_________________________________ Phone #_(______)____________________
Relationship to Patient______________________________

Name_________________________________ Phone #_(______)____________________
Relationship to Patient______________________________
Name_________________________________ Phone #_(______)____________________
Relationship to Patient______________________________
Name_________________________________ Phone #_(______)____________________
Relationship to Patient______________________________

Patient Printed Name____
Patient Signature___________________________________ Date of Signature__________

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Cancellation/No-Show Policy

We ask that you show our office and the other patients courtesy by keeping your scheduled appointments or calling in advance to reschedule when you are aware that you will be unable to keep an appointment. If you fail to do so, you will be charged with a no-show fee that you will be responsible for and that will not be billed to your insurance.

No-Show Office Visit Fee: $25.00

No-Show Ultrasound Fee: $50.00

Due to time constraints related with the ultrasound schedule, we request that you arrive 10 minutes prior to your scheduled ultrasound appointment. If for any reason you are more than 15 minutes late, your ultrasound appointment will need to be rescheduled.

I have read and understand the above office policy.

____ ____________________________________

Your signature Date

PATRICK M TAMIM, M.D.

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PATIENT ACKNOWLEDGEMENT OF HIPAA PRIVACY POLICY: I, the patient or legal guardian, by my signature below, acknowledge that Patrick M. Tamim, M.D. has provided a copy of their HIPAA Privacy Policy. I understand my authorization is not needed for the release of information for the purpose of care, treatment or healthcare options.

SIGNATURE_______________________________________ DATE_________________

ASSIGNMENT AND RELEASE: I, the patient or legal guardian, by my signature below, state that I have insurance coverage and do hereby assign payment of insurance benefits directly to Patrick M. Tamim, M.D., to include third party liability claims. I understand that I am financially responsible for all services and the filing of insurance is a courtesy and this does not alleviate my personal responsibility to pay for rendered service(s). I hereby authorize Patrick M. Tamim, M.D. or any agent of this office to release all medical information necessary to secure payment of services rendered by Patrick M. Tamim, M.D. The assignment and release will remain in effect until revoked and I grant authorization to process both electronic and hard copy submission of claim(s) for payment of my services.

SIGNATURE _____________________________________ DATE__________________

MEDICARE AUTHORIZATION: I request the payment of authorized Medicare benefits be made on my behalf to Patrick M. Tamim, M.D. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated on approved claim forms or electronically submitted claims, my signature authorizes release of information to insurer or agency shown. In Medicare cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE______________________________________ DATE___________________