WT:
HT:
BP:
P:
Temp:

MEDICAL HISTORY FORM

XIAO ZHANG, M.D.
TAMPA BAY ACUPUNCTURE CLINIC
2514 W VIRGINIA AVE
TAMPA, FL 33607

Patient Information: (Please print)

#: **Date:**

Name:	**Age:**	**Sex: Male ☐ Female ☐**
Address:		
City:	**State:**	**Zip Code:**
Home phone:	**Work Phone:**	
Cell Phone:	**E-mail address:** (optional)	
Date of Birth:	**SSN:** (optional)	
Occupation:	**Marital Status:**	
Drug Allergies:	**Referred By:**	

What brings you to our office today? (Chief medical complaint):

_____

How long has the problem bothered you this time? _____

What doctors have you consulted for this ailment? _____

What tests were performed? _____

What was the diagnosis? _____

Significant illnesses: **Seizures** **Depression** **STDs** **Rheumatic fever** **Thyroid disease**

Cancer **Diabetes** **Hepatitis** **Heart disease** **HIV/AIDS** **High blood pressure**

Surgeries: _____

_____

_____

Medical History Form

Family medical history:

Stroke **Cancer** **Diabetes** **Allergies** **Heart disease** **Asthma** **High blood pressure**

☐ **Smoking** **If so, how many/day?** _____ ☐ **Alcohol** **If so, how many/day?** _____

☐ **Coffee** **If so, how many/day?** _____ ☐ **Illegal drugs** **If so, what?** _____

List of current medications/dosage:

_____

_____

_____

List of current vitamins/herbs:

_____

_____

_____

Emergency Contact Information:

Who should we contact in case of an emergency? _____

Emergency phone number: _____

List of family members or other persons whom we may inform about your general medical information:

_____

May we leave confidential messages/appointment reminders on your voicemail or answering machine? ☐ Yes ☐ No

Other problems you would like to discuss:

_____

_____

_____

Please check if you've had the following symptoms (in the last three months):

GENERAL

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Strong thirst (cold or hot drinks)

If so, what time?

- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Other Hair or Skin Issues:
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Headaches
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Other Heart of Blood Vessel Issues:
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty breathing when lying down
- ☐ Other Lung Issues:
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath

GASTROINTESTINAL

☐ Nausea
☐ Constipation
☐ Black stool
☐ Bad breath
☐ Abdominal pain or cramps
☐ Other Stomach or Intestinal Issues:

☐ Vomiting
☐ Gas
☐ Blood in stool
☐ Rectal pain
☐ Chronic laxative use

☐ Diarrhea
☐ Belching
☐ Indigestion
☐ Hemorrhoids

GENITO-URINARY

☐ Pain on urination
☐ Urgency to urinate
☐ Decrease in flow
☐ Frequently wake up to urinate
☐ Other Genital or Urinary Issues:

☐ Frequent urination
☐ Unable to hold urine
☐ Impotency

☐ Blood in urine
☐ Kidney stones
☐ Sores on genitals

REPRODUCTIVE AND GYNECOLOGIC

_____ Number of pregnancies
_____ Miscarriages
_____ Period between menses
_____ Last PAP
☐ Unusual character (heavy or light)
☐ Clots
☐ Breast lumps
☐ Practice birth control

_____ Number of births
_____ Abortions
_____ Duration
☐ Menopause
☐ Irregular periods
☐ Vaginal discharge
☐ Changes in body/psyche prior to menstruation
If so, what type and for how long?

_____ Premature births
_____ Age at first menses
_____ First date of last menses
If so, what age?
☐ Painful periods
☐ Vaginal Sores

MUSCULOSKELETAL

☐ Neck pain
☐ Back pain
☐ Hand/Wrist pain
☐ Other Joint or Bone Issues:

☐ Muscle pain
☐ Muscle weakness
☐ Shoulder pain

☐ Knee pain
☐ Foot/Ankle pain
☐ Hip pain

NEUROPSYCHOLOGICAL

☐ Seizures
☐ Areas of numbness
☐ Concussion
☐ Bad temper
☐ Contemplated suicide
☐ Other Neurological or Psychological Issues:

☐ Dizziness
☐ Lack of coordination
☐ Depression
☐ Easily susceptible to stress
☐ Received treatment for emotional problems

☐ Loss of balance
☐ Poor memory
☐ Anxiety

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

Tampa Bay Acupuncture Clinic
2514 W. Virginia Ave. • Tampa, FL 33607 • (813) 877-9626

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

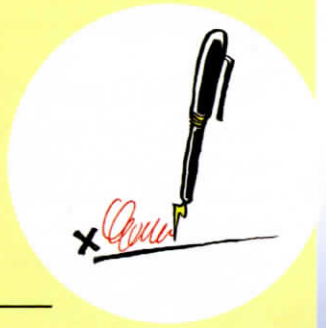
Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!



_____

Patient Signature

Date:_____ /_____ /_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

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