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Today’s Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

 **Personal History Form** *(for patient to fill out)*

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: Y \_\_\_\_ N \_\_\_\_ Drugs, Food, Others (describe reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LATEX Sensitive: Y \_\_\_\_ N \_\_\_\_ Height: \_\_\_\_ (ft) \_\_\_\_(in) Weight: \_\_\_\_\_\_ (lbs)

**Reason for Today’s Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Medical Conditions/Illnesses: *(circle if YES)***

NONE Heart Disease (Type: angina, heart attack, atrial fibrillation) Stroke or TIA

High Blood Pressure High Cholesterol Diabetes Thyroid Disorder (Type: hyper, hypo) Lung Disease (Type: COPD, emphysema, asthma, sleep apnea) Kidney Disease

Bleeding Disorder HIV or AIDS Hepatitis TB Peptic Ulcer

Breast Disease (list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) Cancer (list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Prior Surgeries: *(circle if YES)***

NONE Appendectomy Tonsillectomy Gallbladder Hysterectomy Heart Surgery Pacemaker Back Surgery Joint Surgery Hernia Surgery Weight Loss Surgery

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever had a Colonoscopy? Y \_\_ N \_\_ When & Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had a flu shot this year?** Y\_\_\_ N\_\_\_

**List of Medications** *(Name/Dose/Frequency)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy**: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: *(circle if YES & list relationship to the patient if circled)*** NONE

Cancer (list type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IBD *(Ulcerative Colitis or Crohn’s)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Polyps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Still working: \_\_\_\_ Retired: \_\_\_\_ Disabled: \_\_\_\_

Marital Status (circle): Married – Single – Divorced – Widowed Regular Exercise: Y \_\_\_ N \_\_\_

How much alcohol do you drink each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much do you smoke each day (or when did you quit)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which recreational (non-prescribed) drugs do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much caffeine do you have each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN**: Last Menstrual Period \_\_\_\_\_\_\_\_\_\_ Age Menses Started \_\_\_\_\_\_\_\_\_\_ Age @ Menopause \_\_\_\_\_\_\_\_\_\_

Date & Results: Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age @ 1st Delivery\_\_\_\_ # of Pregnancies\_\_\_\_\_\_ # of Births \_\_\_\_\_\_\_ Did you breastfeed: Y \_\_\_ N \_\_\_

**Review of Systems: *(please circle if YES or choose “NONE” option if NO)***

* Constitutional: NONE - Loss of Appetite - Weight Gain/Loss – Fatigue - Night Sweats – Fevers - Chills
* Hematology: NONE - Bleeding disorder - Easy Bruising - Multiple Blood Transfusions
* Infectious Disease: NONE - Hepatitis – TB – HIV/AIDS
* Psychiatric: NONE - Insomnia – Depression – Anxiety – Memory Loss
* Neurological: NONE - Seizures – Headaches - Numbness or Paralysis of extremities (temporary/permanent)
* HEENT: NONE - Dentures - Hearing Problems – Sinusitis - Wear Glasses - Blurry or Double Vision
* Cardiovascular: NONE - Chest Pain - Heart Palpitations - Take Antibiotics for Dental Procedures
* Peripheral Vascular: NONE - Foot Pain at Rest – Non Healing Sores – Leg cramping
* Pulmonary: NONE - Shortness of Breath with Exercise – Wheezing - Chronic Cough
* Gastro Intestinal: NONE - Nausea - Abdominal Pain – Constipation – Diarrhea - Dark Stools - Blood in Stool
* Genital Urinary: NONE - Kidney Stones – Burning with Urination – Blood in Urine – Difficulty Voiding
* Skin: NONE - Rashes – Jaundice – Eczema – Psoriasis
* Rheum: NONE – Bone Pain – Joint Pain

**ESSEX SURGICAL ASSOCIATES, PC**

Effective date: July 1, 2014

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgment. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting us at 978-922-9226.

By signing this form, you acknowledge receipt of our Privacy Notice and consent to our use and disclosure of protected health information about you for treatment, payment and health care operation. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ESSEX SURGICAL ASSOCIATES, PC**

**PROVIDER NOTICE OF INFORMATION PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 07/01/2014

**USES AND DISCLOSURES OF HEALTH INFORMATION:**  We use health information about you for treatment, to obtain payment for treatment, and for administrative purposes, such as to evaluate the quality of care you receive. We may contact you by mail or telephone to remind you about appointments, and to provide you with information about treatment alternatives or other health –related services that may be of interest to you.

We may use or disclose identifiable health information about you without your authorization for reasons such as public health reporting, auditing purposes , or in emergency situations. We also may provide information when otherwise required to, such as law enforcements activities. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose health information, you can later revoke that authorization to stop any future uses and disclosures in a written request. Our policies for using and disclosing health information may change from time to time. If we make a significant change in our policies, we will change our notice and post the new notice for your review. For information about our privacy practices, please contact us at 978-922-9226.

**INDIVIDUAL RIGHTS:**  You have the right to request restrictions on how your health information is used or disclosed. We will try to accommodate your request, but are not legally required to. You have the right to receive confidential communications from us. For instance, you can request that we contact you at work instead of at home to remind you about appointments or provide you with test results. In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you $.50 (fifty cents) per page. If you think information in your record is incorrect or that important information is missing, you have the right to request that we correct the record or add the missing information. We will try to accommodate your request, however, we are not legally required to. You also have the right to receive a list of where we have disclosed health information about you for reasons other than treatment, payment or administrative purposes or without your written authorization. You have the right to receive a paper copy of this notice whenever you ask for one.

**COMPLAINTS:** If you think that your privacy right has been violated, or if you disagree with a decision we made about the use of access to your records, you may contact us at 978-922-9226. You may also send a written complaint to the U.S. Department of Health and Human Services, 200 Independent Ave, S.W., Washington, DC. The tollfree number is 887-696-6775.

**OUR LEGAL DUTY**: We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices described above. If you have any questions or complaints, please contact us at 978-922-9226.