Patient Medical History Form

Patient Name: ____ **Date of Birth:** _________________

MEDICATIONS TAKEN	DOSE	FREQUENCY	REASON TAKING

If necessary. Please continue listing medications on another piece of paper or on the backside of this form. Your medications are important to Dr. Ginsburg. →

ANY MEDICATION ALLERGIES? **Yes** **No** **If yes, be specific**____________________________________

IMMUNIZATIONS: **Influenza (Flu):** **Yes** **No** **Date:** __________ **Pneumococcal:** **Yes** **No** **Date:** __________

MEDICAL HISTORY

____
____
____

PREVIOUS SURGERIES, SERIOUS INJURIES, HOSPITALIZATIONS

____
____
____

COLONOSCOPY w/in the last 10 years: **Yes** **No** **Date:** _______________ **Physician:** ___________________________

PATIENT SOCIAL HISTORY:

Are you a: Current Smoker ☐ Former Smoker ☐ Never a Smoker ☐ Are you interested in quitting? Yes No
Tobacco Use? No Yes Packs per Day ____ Do you smoke: everyday ☐ some days, but not everyday ☐
Recreational Drug Use? No Yes
Caffeine Consumption: No Yes If Yes, please explain: ____
Alcohol Use? Never Rarely Moderately Daily

FAMILY MEDICAL HISTORY

	Age	Please list diseases and health history	If deceased, cause of death
Father:	________		
Mother:	________		
Siblings:	________		
Children:	________		

Authorization to Access Rx History Information: I hereby authorize Platinum Surgical Care to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

Patient Name: __________________________________ **Signature:** _____________________________ **Date:** ______________

Preferred Pharmacy: ____ Phone Number: __________________________

Location or Address of Pharmacy: ____

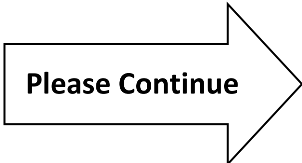
Preferred Laboratory/Radiology Facility to be used for tests/labs: _____________________________ Location: _______________

The following information is now being required for Healthcare/Government reporting purposes**. Please complete ALL 3 questions listed below.**

Race: White Black or African American Hispanic American Indian or Alaskan Native Asian Other ___________

Language: English Spanish Indian Other _____________

Ethnicity/Nationality: Non-Hispanic Hispanic Other _______________



Patient Name: ____ Date of Birth: __________________

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 & THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart disease	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Hypertension	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	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 movement	No	Yes
Nausea or vomiting	No	Yes
Rectal Bleeding or blood in stool	No	Yes
Abdominal Pain	No	Yes

BREAST

Breast discharge	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes

NEUROLOGICAL

Frequent headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions/seizures	No	Yes
Numbness/tingling sensation	No	Yes
Stroke	No	Yes
Head injury	No	Yes

ENDOCRINE

Glandular/Hormone problems	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged Glands	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning/painful urination	No	Yes
Blood in urine	No	Yes
Kidney Stones	No	Yes

CURRENT HEIGHT: __________ WEIGHT: __________

Are you interested in speaking with Dr. Ginsburg regarding diet and exercise? Yes or No (circle one)

Patient Name: ____ Date of Birth: ___________________

WEIGHT HISTORY

Please indicate your weight at the following times, whether you consider your weight was below average, average, above average, or very heavy in the relevant boxes.

	Below Average	Average	Above Average	Very Heavy
Birth Weight				
Weight at 5-10 years				
Weight at age 10-12 years				
Weight at age 15-18 years				
Weight at age 20-29 years				
Weight at age 30-60 years				

Your Current Weight: _______________________________ Height: ____________________________

WEIGHT LOSS HISTORY

Please list all weight loss programs in the past FIVE years you have done.

Program	Dates	Duration	MD Supervised	Amount of Weight Loss
Atkins Diet				
Grapefruit Diet				
Jenny Craig				
Liquid Diets				
Low-calorie/Low fat				
Medically supervised diet				
Medifast				
Metabolife				
Nutri-System				
Optifast				
Personal diet				
SouthBeach				
SlimFast				
TOPS				
Weight Watchers				
Others (Please explain)				

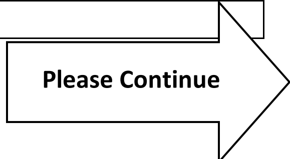
Details of previous weight loss surgery: ____ None: ________

MEDICATIONS

Have you taken medications to assist with weight loss? (Circle One) Yes No

If so, please list them and how long you took them:____

Medication Name	Duration	Amount of Weight Loss
Adipex or Fastin (Phentermine)		
Alli or Xenical (Orlistat)		
Bontril (Phendimetrazine)		
Didrex (Benziphetamine)		
HCG (Human Chorionic Gonadotropin)		
Meridia (Sibutramine)		
Tenuate (Amfepramone)		
Victoza (Liraglutide		
Over-the-Counter Weight Loss drugs		



Patient Name: ____ **Date of Birth:** __________________

OBESITY QUESTIONNAIRE

Non-dietary Therapy

Acupuncture?	No	Yes	Details: ____
Exercise?	No	Yes	Details: ____
Hypnosis?	No	Yes	Details: ____
Behavior Modification?	No	Yes	Details: ____

Sleep History

Do you snore? No Yes

How many hours of sleep do you get a night? ___________

Would you consider the quality of your sleep as: Good Fair Poor

Do you wake during the night with a choking feeling?	Never	Sometimes	Always
How often do you wake up, more than once during the night?	Never	Sometimes	Always
Has anyone noticed that you momentarily stop breathing during your sleep?	Never	Sometimes	Always

Gastroesophageal Reflux/Indigestion

Do you have heartburn or indigestions?	No	Yes
Do you suffer from indigestion at night?	No	Yes
Do you have difficulty swallowing?	No	Yes
Do you have problems with food getting stuck?	No	Yes
Do foods or fluids reflux into your mouth?	No	Yes
Do you have vomiting associated with reflux?	No	Yes
Do you have a hoarse voice?	No	Yes
Do you have recurrent sore throats?	No	Yes
Do you have a regular cough at night?	No	Yes

Breathing History

Have you had prior exposure to gas, vapors, or dust?	No	Yes
Do you have asthma?	No	Yes

Do you have shortness of breath with exertion?	Always	Sometimes	Never
Do you have shortness of breath with walking on flat surfaces?	Always	Sometimes	Never
Do you have shortness of breath with walking up hill?	Always	Sometimes	Never
Do you have wheezing in your chest?	Always	Sometimes	Never
Do you have wheezing that came on after exercise?	Always	Sometimes	Never
Do you have tightness in your chest upon waking in the morning?	Always	Sometimes	Never

How did you hear about us? Please circle all that apply.

Physician Referral Family/Friend TV Radio Facebook

Internet Search Platinum Surgical Care Website Lap-Band Website MDnetSolutions

Mercy Hospital Jefferson Twin Cities Surgery Center Mineral Area Regional Hospital

Other: ___________________________

Platinum Surgical Care
Gregg A. Ginsburg, M.D., F.A.C.S.
1455 Highway 61, Suite B, Festus, MO 63028
5034 Grjffin Road, St. Louis, MO 63128
555 West Pine St., Farmington, MO 63640
Phone number (636) 931-4744 or Toll free 877-931-4744
Fax number (636) 931-4739

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name ______________________________________

Relationship to Patient ______________________________________

Signature ______________________________________

Date ______________________________________

To address any special needs you may have and to assure your patient information is kept confidential please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If so, please list names below for our record.

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Do you authorize our office to call your home and leave a message about test results or other information on your answering machine? YES NO I don’t have a machine

Do you authorize our office to call you at work? YES NO N/A

Comments:____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: ____

Staff Initials: ______________________________ Date: _________________________

Platinum Surgical Care
Gregg A. Ginsburg, M.D., F.A.C.S.
1455 Highway 61, Suite B
Festus, MO 63028
Phone number (636)931-4744 or Toll free 877-931-4744
Fax number (636)931-4739

THIS FORM WILL BE USED TO OBTAIN/RELEASE MEDICAL RECORDS WHEN REQUIRED FOR TREATMENT
PLEASE SIGN AND DATE ONLY OUR OFFICE WILL COMPLETE DOCUMENT IF NEEDED

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Name:_____________________________________ **Date of Birth:** ________________________

I hereby authorize __________________________________to obtain or release protected health information for the purposes described below.

Description of the specific information to be obtained or released:_________________________
____.

The persons in our workforce authorized to make the disclosure is: Medical Records Dept.

The person or entity to whom we will disclose the information, and who may use it, are: ______
____.

The purpose for which the use/disclosed information will be used:
____.

- You may refuse to sign this authorization. Your refusal will NOT affect your ability to obtain treatment, payment or eligibility for benefits.
- If the persons who are authorized to receive the information above are NOT health care providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect it.
- You may inspect or copy the protected health information to be used or disclosed under this authorization. Please send your request to the above address.
- Once you give us this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our office at the above location. However, your revocation will not prohibit us from
    a. any acts we have already taken in reliance of the authorization, or
    b. any right associated with an insurer's contest of a claim under its policy, if the authorization was obtained in order to obtain insurance coverage. If not revoked, this authorization will expire one year from the date of the signature below.

X____ **Date:** ______________________________
Signature (Patient or Legal Representative)
Capacity of Legal Rep.________________________________

NOTICE OF PRIVACY PRACTICES
For
Platinum Surgical Care
Gregg A. Ginsburg, M.D., F.A.C.S

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.

The Health and Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. “HTPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include a physical exam.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a copy of the notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2009, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

U.S. Dept. of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257, Toll free 1-877-696-6775