Seacoast Direct Primary Care

Medical and Personal History

Patient Name: _____

Date: _____ **DOB:** _____ **Gender: M / F** **Preferred Pronouns:** He / Him She / Her They / Them

Please check conditions which you have had in the past and when:

CVS
- ○ Rheumatic Fever
- ○ High Cholesterol
- ○ Congestive Heart Failure
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Angina
- ○ Frequent Chest Pain
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Blood Clots in Veins
- ○ Blocked Arteries in Neck
- ○ Blocked Arteries in Legs

Lymphatic / Hematologic
- ○ Diabetes Mellitus
- ○ Overactive Thyroid
- ○ Underactive Thyroid
- ○ Anemia
- ○ Thyroid Goiter
- ○ Blood Transfusion
- ○ Lyme Disease

Skin / Breast
- ○ Acne
- ○ Eczema / Psoriasis
- ○ Fibrocystic Breast Disease
- ○ Abnormal Mammogram
- ○ Rashes
- ○ Hives
- ○ Moles
- ○ Shingles

Respiratory
- ○ Sleep Apnea/Snoring
- ○ Frequent Bronchitis
- ○ Emphysema
- ○ Pneumonia
- ○ Asthma
- ○ Clots in Lungs
- ○ Tuberculosis

Musculoskeletal / Extremities
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Joint Pain
- ○ Gout
- ○ Broken Bones
- ○ Osteoporosis
- ○ Osteopenia
- ○ Fibromyalgia
- ○ Neck Pain (hern. disc)
- ○ Back Pain (herniated disc)

HEENT
- ○ Glasses / Contacts
- ○ Glaucoma
- ○ Cataracts
- ○ Hearing Loss
- ○ Frequent Ear Infections
- ○ Ringing in Ears
- ○ Allergies
- ○ Frequent Sinus Infections
- ○ Mouth Sores

Neurologic / Psychiatric
- ○ Seizure
- ○ TIA
- ○ Stroke
- ○ Numbness
- ○ Weakness
- ○ Memory Loss
- ○ Migraine Headaches
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks
- ○ Suicide Attempt
- ○ Physical Abuse
- ○ Sexual Abuse
- ○ Mental Illness
- ○ Dizziness
- ○ Vertigo
- ○ Peripheral Nerve Disease
- ○ Insomnia
- ○ Alcohol/drug addiction

General
- ○ Abnormal Weight Loss
- ○ Abnormal Weight Gain
- ○ Cancer/Tumor _____

_____

_____# of Pregnancies

_____Live Births

_____ Miscarriages

_____Abortions

GI /GU
- ○ Heartburn
- ○ Stomach Ulcers
- ○ Gallstones
- ○ Blood in Stool
- ○ Hepatitis A, B or C
- ○ Diarrhea / Constipation
- ○ Hemorrhoids
- ○ Abdominal Pain
- ○ Colon Polyps
- ○ Urinary Frequency
- ○ Bladder Infections
- ○ Prostate Disease
- ○ Urinary Incontinence
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Ulcerative Colitis
- ○ Crohn's Disease
- ○ Diverticulitis/Diverticulosis
- ○ Irritable Bowel Disease
- ○ Cirrhosis of the Liver
- ○ Liver Failure
- ○ Pancreatitis
- ○ Endometriosis
- ○ Abnormal PAP
- ○ Sex Transmitted Infection
- ○ HIV Infection

Please list any allergies or intolerance to drugs or other substances:

_____

_____

Please list the medications and supplements you take, their dosages, how many times per day you take them:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list ALL medications and supplements with dosages that you have tried, when, and why they were ineffective:

_____ _____ _____

_____ _____ _____

Seacoast Direct Primary Care

Please indicate any surgeries you have had and the year you had them:

○ Angioplasty _____	○ Trauma Related _____	○ Stomach_____	○ Tubal Ligation _____
○ Carotid Artery _____	○ Back/neck _____	○ Inguinal Hernia _____	○ C-Section _____
○ Other Vascular _____	○ Hip _____	○ Colonoscopy _____	○ Hysterectomy _____
○ Coronary Bypass _____	○ Knee _____	○ Gallbladder _____	○ Ovary Removed _____
○ Chest/Lung _____	○ Carpal Tunnel _____	○ Appendectomy _____	○ Breast _____
○ Tonsillectomy _____	○ Sinus _____	○ Prostate _____	○ Thyroid _____
○ Neurosurgery _____	○ Ear_____	○ Bladder _____	○ Other _____

Provider Notes: _____

Please indicate when you last had any of the following preventative tests or services:

○ Cardiac Angiogram _____	○ Flu Vaccine _____	○ PSA Blood Test_____	○ Colonoscopy _____
○ Stress Test _____	○ Pneumonia Vaccine _____	○ Rectal Exam _____	○ Mammo/Breast Exam ____
○ EKG _____	○ Tetanus Vaccine _____	○ Colon Cancer Stool Test _	○ PAP Smear _____
○ Chest X-Ray _____	○ Hepatitis Vaccine _____	○ Flexible Sigmoidoscopy ____	○ Last Menstrual Period ____
○ Echocardiogram _____	○ Bone Density Test _____	○ Covid vaccine_____	○ Dental Exam _____

Provider Notes: _____

Family Medical History

Please check major illness in your family members and indicate which family member affected

○ Tuberculosis	○ Diabetes Mellitus	○ Kidney Disease	○ Breast Cancer
○ Emphysema	○ Thyroid Disease	○ Epilepsy	○ Ovarian Cancer
○ Heart Disease	○ Anemia	○ Neurologic Disorder	○ Colon Cancer or polyps
○ High Blood Pressure	○ Hemophilia	○ Liver Disease	○ Prostate Cancer
○ Osteoporosis	○ High Cholesterol	○ Hepatitis	○ Skin Cancer

Personal Information

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

What is or was your occupation? _____

Who currently lives in your home? _____

Have you ever felt threatened or do you currently feel threatened (emotionally/physically) in your home? _____

Are you sexually active? ○ **Not Active** ○ **Heterosexual** ○ **Homosexual** ○ **Bisexual**

Do you or your partner use condoms (practice safe sex)? ○ **Always** ○ **Never** ○ **Sometimes**

History of tobacco use: Current _____ **Past** _____ **how many years?** _____ **Packs per day** _____ **When quit** _____

Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc.)? _____

How much alcohol do you consume? ○ None # _____ **per week, if rare #** _____**/year**

What are your current dietary patterns? _____

Exercise how often ? _____**times per** _____**for how long** _____**Type** _____

Patient Signature: _____**Provider Signature:** _____**MD/DO/PA-C**

Seacoast Direct Primary Care

Review of Current Symptoms

Patient Name: _____

Date: _____ **DOB:** _____

Please check conditions you have experienced recently: (within the past one year)

General
- ○ Good general health
- ○ Always tired
- ○ Always feel ill
- ○ Chronic fatigue
- ○ Loss of appetite
- ○ Wt loss > 10lbs
- ○ Wt gain > 10lbs
- ○ Unexp fever > 100°
- ○ Night sweats
- ○ Chills

HEENT
- ○ Eye pain
- ○ Eye drainage
- ○ Watery eyes
- ○ Itchy eyes
- ○ Spots in vision
- ○ Blurry vision
- ○ Double vision
- ○ Light flashes
- ○ Loss of vision
- ○ Ear pain
- ○ Ear drainage
- ○ Ear ringing
- ○ Hearing loss
- ○ Runny nose
- ○ Nasal congestion
- ○ Nose bleeds
- ○ Hay fever
- ○ Sinus pain
- ○ Freq sinus infections
- ○ Frequent colds
- ○ Recent voice change
- ○ Freq sore throat
- ○ Hoarseness
- ○ Laryngitis
- ○ Swallowing pain

Heart/Circulation
- ○ Chest pain
- ○ Palpitations
- ○ Skipped heart beats
- ○ Extra heart beats
- ○ Fast heart beats
- ○ High blood pressure
- ○ Calf pain/calf cramps
- ○ Ankle swelling
- ○ Blood clot in veins
- ○ Cold, purple feet

Respiratory
- ○ Shortness of breath
- ○ Wheezing
- ○ Cough
- ○ Coughing up blood
- ○ Snoring
- ○ Sleep apnea
- ○ Fluid in lungs

Gastrointestinal
- ○ Persistent nausea
- ○ Unexplained vomiting
- ○ Frequent heartburn
- ○ Abdominal bloating
- ○ Swallowing difficulties
- ○ Abdominal cramps
- ○ Black stool
- ○ Bloody stool
- ○ Constant diarrhea
- ○ Constant constipation
- ○ Change in bowel habits
- ○ Bleeding from bowels
- ○ Anal / rectal pain
- ○ Hemorrhoids
- ○ Loss of bowel control
- ○ Require laxatives

Genitourinary
- ○ Painful urination
- ○ Urine control trouble
- ○ Urinate >2 times/night
- ○ Blood in urine
- ○ Testicle lump/swelling
- ○ Penile discharge/sores
- ○ Irregular periods
- ○ Heavy periods
- ○ No periods
- ○ Vaginal discharge/itch
- ○ Possibly pregnant
- ○ Pain with sex
- ○ Lack of sex drive
- ○ No erection/orgasm

Musculoskeletal / Extremities
- ○ Joint pain/stiffness
- ○ General muscle aches
- ○ Pain neck/back
- ○ Pain hip/knee/foot
- ○ Pain shoulder/elbow
- ○ Pain wrist/hand

Skin/Breast
- ○ Unexplained rash
- ○ Change in skin color
- ○ Dry skin
- ○ Itching
- ○ Unusual/changed mole
- ○ Boils
- ○ Skin growths
- ○ Breast pain/lump
- ○ Nipple discharge

Neurologic
- ○ Frequent headaches
- ○ Blackouts/fainting
- ○ Dizzy/light headed
- ○ Poor balance
- ○ Difficulty walking
- ○ Tremors
- ○ Memory loss
- ○ Speech problems
- ○ Loss of strength
- ○ Seizures
- ○ Numbness

Psychiatric
- ○ Anxious
- ○ Depressed
- ○ Hyperactive
- ○ Attention deficit
- ○ Excess fear/worry
- ○ Loss of interest in life
- ○ Suicidal thoughts
- ○ Unusual visions
- ○ Difficulty concentrating
- ○ Difficulty getting to sleep
- ○ Difficulty staying asleep
- ○ Impulsive

Endocrine
- ○ Most always cold
- ○ Most always hot
- ○ Overweight
- ○ Abnormal hair growth
- ○ Hair loss
- ○ Change in skin color
- ○ Excess thirst
- ○ Excess urination
- ○ Irregular menstrual cycles
- ○ Excessive sweating
- ○ Hot flashes

Lymphatic / Hematologic
- ○ Blood transfusion
- ○ Easily bruised
- ○ Lymph node swelling
- ○ Swollen extremities

Allergic/Immunologic
- ○ Allergies to medicines
- ○ Allergies to cosmetics
- ○ Allergies to food
- ○ Hives
- ○ Hay fever

Infectious Disease
- ○ Contact with blood
- ○ Contact with body fluids
- ○ Recurrent skin infections
- ○ Frequent foreign travel

Miscellaneous
- ○ Chemical exposures
- ○ Toxic exposures
- ○ Radiation exposures
- ○ Occupational exposures
- ○ Sick pets
- ○ Drink well water
- ○ Drink unpasteurized milk
- ○ Process own meats

Other

_____

_____

_____

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Seacoast Direct Primary Care

Acknowledgement of Receipt of Notice of Privacy Practices and Agreement to Disclosures to Family, Friends and Others

Patient Name: _____ **Date of Birth:** _____

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") requires us, Freedom Family Medicine (office), to give you a notice of our privacy practices and to ask you to acknowledge your receipt of the notice.

What is the Notice of Privacy Practices?

The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights regarding your protected health information, as well as our legal responsibilities.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

I understand that, under 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.
- Conduct health care operations such as quality assessments and physician certifications.

I acknowledge that I have received Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Seacoast Direct Primary Care has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time at 603-828-1195 to obtain a current copy of the Notice of Privacy Practices.

DISCLOSURES TO FAMILY, FRIENDS AND OTHERS INVOLVED IN HEALTH CARE

I agree that Seacoast Direct Primary Care may share my medical information with the individuals listed below who are involved in my care or payment for my care. I understand that Site will only share medical information about me that is relevant to the individual's involvement with my care.

☐ Yes ☐ No Spouse (name): _____

☐ Yes ☐ No Children (name): _____

☐ Yes ☐ No Friend (name) _____

☐ Yes ☐ No Other (name): _____

Patient / Personal Representative Signature: _____

Relationship of Personal Representative: _____

Date: _____

***FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Patient refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please describe: _____)

Seacoast Direct Primary Care

Seacoast Direct Primary Care

200 Lafayette Rd. Ste. 4
North Hampton, NH 03862
Phone 603-379-2844 Fax 603-379-2860

Request for Medical Records

Patient's Name: _____

Address: _____

Telephone: _____ **Date of Birth**: _____

☐ **Records to be sent to** ☐ **Records to be received from**

Provider's Name: _____

Provider's Address: _____

Provider's Phone: _____ **Provider's Fax**: _____

I hereby request that the Practice provide me a copy of the "Requested Information" checked below.

_____ All Medical Records

_____ Test Results for: _____

_____ Other: _____

I am interested in obtaining a copy of the "Requested Information" relating to the time period:
_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information.
_____ (Initial)

I understand that the Practice may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the practice who did not participate in the Practice's decision to deny my request.

I understand that the Practice will notify me of its decision to approve or deny my request for access or obtain a copy of the Requested Information within 30 days of receiving this request if the information is maintained or accessible on-site at the Practice or within sixty days if the Requested Information is not maintained on-site at the practice. If the Practice is unable to comply with my approved request within 30 days, they will notify me in writing.

I understand that the Practice will notify me prior to copying my information of any fees for copying, processing, or mailing my records.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed name of Personal Representative/Relationship to Patient