MIDWAY
PRIMARY CARE CENTER

Raja Talati, MD
Ashley Quidaciolu, APRN-BC
1801 SE Hillmoor Dr. C-207
Port St. Lucie, FL 34952
P: (772) 742 - 9270
F: (772) 335 - 4236
www.midwaycare.org

New Patient Questionnaire

Personal Information

Today's Date: _____

Last Name, First Name, Middle Initial: _____ Date of Birth: _____

Preferred Name: _____ Social Security Number: _____

Gender Assigned at Birth: □ Female □ Male □ Intersex □ Prefer not to answer
Relationship Status: □ Single □ Sig Other □ Separated □ Married □ Divorced □ Widowed

Home Address: _____ City, State and Zip Code: _____
Mailing Address: □ Same as Above
_____ _____ City, State and Zip Code: _____

Phone Number(s) □ Home: _____ □ Cell: _____ □ Work: _____
Check box representing preferred number for patient reminders, etc.

Email Address: _____ Enable Patient Portal: □ Yes □ No

Emergency Contact: _____ Phone: _____ Relationship: _____

Name of Primary Care Provider: _____

Address: _____ City, State and Zip Code: _____

Employment Status: □ Full time □ Part time □ Retired □ Self □None
Student: □ Full time □ Part time □None

Employer Name/School Name: _____

Address: _____ City, State and Zip Code: _____

Occupation: _____

Who may we thank for referring you: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Financial Responsible Party: _____

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New Patient Questionnaire – Continued

Race:
- □ American Indian
- □ Asian
- □ Native Hawaiian
- □ Black or African American
- □ White
- □ Other Race
- □ Other Pacific Islander
- □ Decline to answer

Ethnicity:
- □ Hispanic or Latin
- □ Not Hispanic or Latin
- □ Decline to answer

Preferred Language:
- □ English
- □ Spanish
- □ Portuguese
- □ Other: _____

Name of Your Local/Mail Order –Check the preferred one

Pharmacy	**Address**	**Telephone Number**
□		
□		

I hereby consent to Midway Primary Care Center, Inc .obtaining my **Prescription History** from any/all sources.

Patient's Signature:

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Today's Date: _____

Last Name, First Name, Middle Initial: _____ Date of Birth: _____

Medication History

Please list all medications you are currently taking
(Include Over-The-Counter Medications and/or Supplements)

Name of Medication	Dosage	Directions for use	Reason for use

Do you have any Drug or other Allergies: □ Yes □ No

Drug allergy	Reaction	Age of onset

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Today's Date: _____

Last Name, First Name, Middle Initial: _____ Date of Birth: _____

Current/Past Medical History

Do you currently have any of the following symptoms? *(Check those that apply)*

- □ Rash, itchy skin or skin disorder
- □ Sinus congestion
- □ Hearing loss
- □ Cough
- □ Fever
- □ Chest pain or palpitations
- □ Constipation or diarrhea
- □ Vaginal or penile discharge
- □ Genital or rectal warts or ulcers
- □ Muscle pain or joint swelling
- □ Poor appetite
- □ Suicidal thoughts
- □ Anxiety/stress
- □ Change in vision
- □ Difficulty swallowing
- □ Dental problems
- □ Shortness of breath
- □ Night sweats
- □ Nausea and/or vomiting
- □ Blood in stool or hemorrhoids
- □ Painful urination
- □ Muscle weakness
- □ Tingling burning, pain or numbness in extremities
- □ Sudden weight loss or gain
- □ Suicide attempts
- □ Unexplained fatigue/weakness

Please list any other symptoms or health concerns that you would like to discuss with your healthcare provider today:

_____ _____

_____ _____

_____ _____

Do you have any of the following conditions? *(Check those that apply)*

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Blood Disorder
- □ Breast lump
- □ Bronchitis
- □ Bulimia
- □ CAD/heart disease
- □ Cancer, type: _____
- □ Chemical dependency
- □ Depression
- □ Diabetes
- □ Emphysema/COPD
- □ Epilepsy/seizures
- □ GERD/reflux
- □ Glaucoma
- □ Goiter
- □ Gout
- □ Hair loss
- □ Heart Attack
- □ High cholesterol
- □ Neuropathy
- □ High blood pressure
- □ HIV positive
- □ Kidney Disease
- □ Liver Disease
- □ Multiple Sclerosis
- □ Pacemaker
- □ Mental illness
- □ Migraines
- □ Osteoporosis
- □ Stroke
- □ Thyroid disease
- □ Heart disease
- □ Lung problems
- □ Rheumatic fevers
- □ Rhinitis
- □ Back or joint problems
- □ Prostate problem
- □ cervical problem
- □ Other:

_____

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Have you had any of the following diseases or other issues?

□ Syphilis, If yes, what was your most recent titer and when? _____
□ Gonorrhea
□ Chlamydia
□ Venereal warts
□ Genital herpes
□ Hepatitis A, B, or C, if yes, which one(s) and most recent viral load if chronic?_____

Any other conditions you are followed by a doctor or take any medication for? _____

_____

Vaccination & Healthcare History:

BOTH MEN AND WOMEN

□ Flu Shot, if yes when? _____
□ Covid-19 vaccine, if yes, which one and when? _____
□ Hepatitis A Shot, did you complete the series and when? (2 shots) _____
□ Hepatitis B Shot, did you complete the series and when? (3 shots) _____
□ Measles, Mumps Rubella (MMR) shot, did you complete the series and when? _____
□ Varicella Shot, if yes when? _____
□ Pneumonia Vaccine, if yes which one (s) _____
□ Tetanus Booster, if yes when? _____
□ Tdap/TD, if yes when?_____
□ HPV, if yes did you complete series and when (3shots)? _____
□ Tuberculosis (PPD) test, if yes when? _____
Have you ever had a positive PPD test? □ Yes, Explain: _____ □ No
Have you ever had Meningitis? □ Yes, Explain: _____ □ No
Last Cholesterol testing: _____
Last eye exam: _____
Last dental exam: _____
Last Colonoscopy: _____
Last Dexa scan: _____
Have you ever had a blood transfusion? □ Yes, Year: _____ Explain: _____ □ No

WOMEN ONLY

Last Pap Smear: _____
Last Mammogram: _____
Last menstrual cycle: _____

MEN ONLY

Last PSA (Prostate blood test): _____
Digital rectal exam: _____

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Today's Date: _____

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Sexual and behavioral Questionnaire

My gender identity is: □ Female □ Male □ Transgender (MTF) □ Transgender (FTM) □ Other _____ □ Decline
I live: □ alone □ with spouse □ with roommate(s) □ with parents/family □ am homeless □ Other _____
My sexual orientation is: □ Bisexual □ Heterosexual □ Homosexual □ Other_____ □ Not sure
My pronouns are: □ She/her □ He/Him □ They/Them/Their □ Other _____
Do you currently have sex? □ Yes □ No
Sexual practices? □ Vaginal □ Anal □ Oral □ Other, _____
Do you use condoms or some type of barrier protection? □ Yes □ No
Birth control method? □ Oral Contraception □ IUD or other implant □ None □ N/A
Have you ever been in jail or prison? □ Yes When? _____ □ No
Do you use tobacco products? □ Yes, □ Smoke □ Chew □ Vape □Other: _____ □ No
If yes, what are they? _____ And how often? _____ Are you ready to quit? □ Yes □ No
If no, have you ever smoked? _____ How long ago did you quit? _____
Do you have a history of using IV drugs or "street" drugs? □ Yes □ No
If yes, which one(s): _____ How long ago did you quit? _____
Do you drink alcohol? □ Yes □ No
If yes, how many drinks per day? _____ How many times a week? _____
Did you ever have a problem with alcohol or other substances? □ Yes □ No
If yes, please explain: _____
Do you drink coffee or other caffeine products? □ Yes □ No
If yes, which _____ How many cups per day? _____
Place of Birth? City, State, Country _____
Have you traveled out of the country □ Yes □ No
If yes where and when? _____

Thinking of the last two weeks:
Have you been feeling down, depressed or hopeless? □ Yes □ No

Thinking of the last two weeks:
Have you had little interest or pleasure in doing things? □ Yes □ No

Have you ever been non-consensually hit, slapped, kicked or otherwise been physically hurt by an intimate partner?
□ Yes □ No If yes, how long ago? _____

Have you ever been forced to have sexual activity against your will? □ Yes □ No
If yes, when did this happen? _____Was the incident reported to authorities? □ Yes □ No

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PATIENT SIGNATURE: _____

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Surgical History

Surgery Name	Year

Hospitalization History

Hospital/Facility	Reason	Year

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Patient Self Determination Act Questionnaire

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of the Florida Statutes, Please answer the following questions by initialing the applicable response:

Declaration to decline Life-Prolonging Procedure (Living Will)
_____I have such a declaration (Please provide a copy)
_____I have NOT made such a declaration

Health Care Surrogate
_____I have a designated health care surrogate Name: _____
_____I have NOT designated a health care surrogate

Durable Power of Attorney
_____I have appointed a durable power of attorney (Please provide a copy)
_____I have NOT appointed a durable power of attorney

24-Hour Cancellation & No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is unable to receive care. Midway Primary Care Center, Inc. reserves the right to charge a fee of $25.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

"No-Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple no-shows in any twelve (12) month period may result in discharge from the Practice.
Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have reviewed this notice and understand the policy.

Printed Name: _____

□ Self or Relationship to Patient: _____

Signature: _____

Date: _____

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CONSENTS

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we ask your permission before disclosing certain healthcare information to certain people or entities.

In accordance with the Act, I _____ Hereby authorize Midway Primary
(Patient signature)
Care Center, Inc. to release any information regarding my health to the following persons or entities:

Name	Date of Birth	Relationship	Phone Number

Leaving Messages for You

In the event that I am not available when Midway Primary Care Center, Inc. calls with medical information:
*(Please check the applicable box **and** initial beside it.)*

□ _____ Please DO leave messages on my answering machine or voicemail.
□ _____ Please DO NOT leave messages on my answering machine or voicemail.
□ _____ I DO NOT HAVE an answering machine or voicemail.

Insurance Authorization and Assignment

All Charges are payable at the time of service.

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage; it is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment: I hereby authorize Midway Primary Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Printed Name: _____

□ Self or Relationship to Patient: _____

Signature: _____

Date: _____

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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:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. 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 **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Printed Name: _____

□ Self or Relationship to Patient: _____

Signature: _____

Date: _____

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To:_____
_____
_____

Authorization of Release of Medical Records

Name of Patient:_____

Social Security: _____

I authorize the release of my medical records specifically to include the following:

_____ Complete medical Records
_____ Lab Reports
_____ Consultations
_____ Medications
_____ Other

This medical record may contain information about drug abuse, substance abuse, mental health treatment and HIV/AIDS information. Separate consent must be given to release this information.

_____ I DO consent to having this information disclosed.

_____ I DO NOT consent to having this information disclosed.

The purpose of this request is for diagnosis and treatment.
These records are to be sent to the above address.
This authorization will expire 90 days from the date of signing.
I have the right to revoke this authorization at any time in writing except to the extent of information that has already been released.

I have reviewed this authorization. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

Date: _____

_____
Signature of Patient or Personal Representative