



Sreevani Vemuri MD  
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Jupiter, Florida 33458  
(561) 427-6550 telephone  
(561) 677-3722 fax

### New Patient Questionnaire

**\*\*Who may we thank for referring you\*\*:** \_\_\_\_\_

#### 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 Status: ☐ Full time ☐ Part time ☐ None

Employer Name/School Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State and Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_

#### 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**

- ☐ \_\_\_\_\_
- ☐ \_\_\_\_\_

### **Use of 340B Contract Pharmacy**

Contract pharmacies offer a range of customizable clinical and operational services that enhance the safety, quality, and affordability of care for our patients. Our 340B network of pharmacies was chosen based on a wide variety of performance and cost-saving criteria. We review each pharmacy that we add to our network to determine their true capabilities and services before entrusting our patients to their care. Using our 340B program helps to provide funds for increased client services such as a case manager and in-house lab and mental health and help us provide care for uninsured patients.

- ☐ Yes, Sign me up      ☐ No, not at this time      ☐ I would like more information

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

Patient's Signature: \_\_\_\_\_



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Last Name, First Name, Middle Initial: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
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 |
|--------------------|--------|--------------------|----------------|
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
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|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |
|                    |        |                    |                |

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



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Drug allergy

Reaction

Age of onset

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)*

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



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

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

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



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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? \_\_\_\_\_
- ☐ 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: \_\_\_\_\_



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Last menstrual cycle: \_\_\_\_\_

**MEN ONLY**

Last PSA (Prostate blood test): \_\_\_\_\_

Digital rectal exam: \_\_\_\_\_

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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 pronoun is: ☐ 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? \_\_\_\_\_



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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

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### **Surgical History**

Surgery Name

Year

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### **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 Specialty 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 Specialty  
(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

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### Leaving Messages for You

In the event that I am not available when Midway Specialty 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 Specialty 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.

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges.

Printed Name: \_\_\_\_\_



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☐ Self or Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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