Michael E. Dunn, MD, AAHIVS
Rodrigo Sabec, APRN, FNP
Michael Cooley, APRN, AGNP-C
- **3317 W Gandy Boulevard**
- **Tampa, FL 33611**
- **5224 East Fowler Avenue**
- **Temple Terrace, FL 33617**

*Ph:(813) 902-8600*
*Fax:(877) 231-7263*
*www.midwaycare.org*

# New Patient Questionnaire

| **Personal Information** | Date: | Date of Birth: |
|---|---|---|
| Last Name, First Name, Middle Initial: | | |
| Preferred Name: | | |
| Main reason for visit: | | |
| Social security #: | | |
| Pronouns: | □ She/Her/Hers<br>□ He/Him/His<br>□ They/Them/Theirs<br>□ Ze/Hir/Hirs<br>□ Other: ______ | |
| Sex Assigned at Birth: | □ Female □ Male □ Other: ______ | |
| What is your current gender identity? | □ Male<br>□ Female<br>□ Transgender Male/ Transgender Man/ Female-to-Male (FTM)<br>□ Transgender Female/ Transgender Woman/ Male-to-Female (MTF)<br>□ Non-binary/Genderqueer/Gender Fluid<br>□ Prefer to self-describe: _________<br>□ Choose not to disclose | |
| Relationship status: | □ S □ Sig Other □ Sep. □ M □ D □ W □ Other _______ | |
| Home Address: | | |
| City, State and Zip Code: | | |
| Mailing Address: □ Same as above | | |
| City, State and Zip Code: | | |
| Phone Number(s) *Check box representing preferred number for patient reminders, etc.* | □ Home: __________________ □ Cell: __________________<br>□ Work: __________________ | |
| Email Address: | | |

| Enable Patient Portal: | □ Yes □ No | |
|---|---|---|
| Emergency Contact / Relationship | | |
| Name of Primary Care Provider:<br>Phone number of PCP | | |
| Employer Name: | | |
| Employer Address: | | |
| City, State and Zip Code | | |
| Your Occupation: | | |
| **Insurance Information** | | |
| Primary Insurance Company: | | |
| Telephone Number: | Policy Number: | Group Number: |
| Secondary Insurance: | | |
| Telephone Number: | Policy Number: | Group Number: |
| Policy Holder / Subscriber's Name | | |
| Financially Responsible Party: | | |

**Race:**
- □ Alaska Native
- □ American Indian
- □ Asian
- □ Asian Indian
- □ Black or African American
- □ Haitian
- □ Native Hawaiian
- □ Other Pacific Islander
- □ White
- □ Other Race
- □ Decline to Specify

**Ethnicity:**
- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Other
- □ Decline to Specify

**Language:**
- □ English
- □ Spanish
- □ Creole
- □ Other: ______

## How did you hear about Midway Specialty Care Center? ____________________

| | Name & Address | Telephone Number |
|---|---|---|
| Name of Your Local Pharmacy | | |

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

**Patient's Signature:**

# Medical Questionnaire

| | |
|---|---|
| **Medications:**<br>Please list all medications you are currently taking (including Over-The-Counter medications and/or supplements) | |
| **Allergies:**<br>Do you have drug allergies or other allergies? | |
| **Surgical History:**<br>If any, list month/year and what procedure. | |
| **Hospitalizations:**<br>If any, list month/year and what reason. | |

**Past Medical History, Family History:** Do you have or is there a family history of the following? Check those that apply

| Health Condition | Self | Family | Health Condition | Self | Family |
|---|---|---|---|---|---|
| Alcoholism | | | HIV | | |
| Anemia | | | Kidney Disease | | |
| Bleeding Disorder | | | Mental Health Condition | | |
| Cancer | | | Frequent Headaches or Migraines | | |
| Diabetes | | | Osteoporosis | | |
| Epilepsy/Seizures/ Convulsions | | | Stroke | | |
| Glaucoma | | | Thyroid Disease | | |
| Hair Loss | | | Heart Disease | | |
| Heart Problems | | | Lung Problems | | |
| High Cholesterol or Triglycerides | | | Back or Joint Problems | | |
| High Blood Pressure | | | Prostate or Cervical Problems | | |
| Other | | | Other | | |

**Other past medical history:** ______________________________

**Other family medical history:** ______________________________

| Vaccination & Healthcare History: | Approximate Date |
|---|---|
| Flu Shot | |
| COVID vaccine | |
| Hepatitis A shot | |
| Hepatitis B shot | |
| HPV vaccine | |
| Pneumonia 23 vaccine | |
| Pneumonia 13 vaccine | |
| Tetanus shot (TDAP) | |
| Tuberculosis PPD or QuantiFERON Tuberculosis Test | |
| Have you ever had a positive PPD test? | |
| Meningitis vaccine | |
| MMR | |
| Varicella | |
| Pap smear | |
| Mammogram | |
| Eye exam | |
| Dental exam | |
| Colonoscopy or FIT test – circle kind? | |
| DEXA scan | |
| Have you ever had a blood transfusion? | |
| Have you traveled out of the country? | Where and when? |

# Do you have any of the following symptoms?

| Symptom | Yes | No | Symptom | Yes | No |
|---|---|---|---|---|---|
| Rash, itchy skin or skin disorder | | | Change in vision | | |
| Sinus congestion | | | Difficulty swallowing | | |
| Hearing loss | | | Dental problems | | |
| Cough | | | Shortness of breath | | |
| Fever | | | Night sweats | | |
| Chest pain or palpitations | | | Nausea and/or vomiting | | |
| Constipation or diarrhea | | | Blood in stool or hemorrhoids | | |
| Vaginal or penile discharge | | | Painful urination | | |
| Genital/Rectal warts or ulcers | | | Muscle weakness | | |
| Muscle pain or joint swelling | | | Tingling, burning, pain or numbness in extremities | | |
| Poor appetite | | | Sudden weight loss or gain | | |
| Suicidal thoughts | | | Suicide attempts | | |
| Anxiety/stress | | | Unexplained fatigue/weakness | | |

**If yes to any of those symptoms, please notify the provider.** (FOR OFFICE USE ONLY)

# Social History

| | |
|---|---|
| Do you smoke cigarettes? | □ Yes □ No, how long/much? |
| Are you interested in quitting smoking? | □ Yes □ No □ N/A |
| If you are a former smoker, when did you quit? | |
| Do you use other tobacco products? (Pipe, cigar, snuff, chew) | □ Yes, circle kind. □ No |
| Have you been sexually active in the past year? | □ Yes □ No<br>If so, how many partners in the past 1 year?<br>__________ |
| Are you sexually active with... | □ Men □ Women □ Trans Male □ Trans Female<br>□ All of the above |
| Do you use condoms? | □ No □ All the time □ Most of the time □ Half of the time<br>□ Some of the time |
| Have you ever had an STD (Sexually Transmitted Disease)? | □ Yes, circle kind. □ No<br>Chlamydia, Gonorrhea, Syphilis, Herpes, Hepatitis C, Warts. |
| Sexual orientation: (check all that apply) | □ Straight or Heterosexual □ Pansexual<br>□ Lesbian, Gay or Homosexual □ Asexual<br>□ Bisexual □ Don't Know<br>□ Queer □ Choose not to disclose<br>□ Other: __________ |
| Do you have any tattoos? | □ Yes □ No |
| Have you ever been in jail or prison? | □ Yes □ No |
| Sexual practices? (check all that apply) | □ Vaginal □ Anal □ Oral |
| Birth control method? | □ Oral pills □ Depo shot □ IUD or other implant □ None<br>□ N/A |
| Pregnant? | □ Yes □ No □ Don't know □N/A |
| Have you ever used any substances? (Crystal Meth, Heroin, Opioids, Fentanyl, Ecstasy, Mushrooms, LSD, Cocaine, Crack) | □ Yes, circle kind. □ No<br>□ Other: __________ |
| Have you ever injected any drug? | □ Yes □ No |
| Are you still using any drugs? | □ Yes, drug of choice: __________<br>□ No |
| Have you ever been in a substance use rehab program? | □ Yes □ No □ N/A |
| Have you ever been on Suboxone or Methadone? | □ Yes, circle kind. □ No □ N/A |
| Are you interested in quitting substances? | □ Yes □ No □ N/A |
| Do you drink alcohol? □ Beer/Wine □ Liquor | □ Yes, frequency?<br>□ No |
| Any history of alcohol dependence? | □ Yes □ No □N/A |
| Do you have any children? | □ Yes □ No |

| Is it difficult for you to get transportation to your appointment? | □ Yes □ No |
|---|---|
| Do you have any problems with your housing such as unsafe/unclean conditions, temporary living, or no place to live? | □ Yes, circle kind. □ No |
| In the past 12 months, did you ever worry that your food would run out before you had money to buy more? | □ Yes □ No |
| In the past 12 months, did your food ever not last and you didn't have money to get more? | □ Yes □ No |
| In the past 12 months, did you have trouble paying for:<br>(check all that apply) | □ Food □ Rent/Mortgage □ Medical Care □ Prescriptions<br>□ Insurance □ Gas/Electricity □ Childcare<br>□ Other: ______ |

**Additional Questionnaire**

| Have you ever been on a non-consensually hit, slapped, kicked, or otherwise been physically hurt by an intimate partner? | □ Yes, how long ago?<br>□ No |
|---|---|
| Have you ever been forced to have sexual activity against your will? | □ Yes, when did this happen?<br>Was the incident reported to authorities?<br>□ No |

**If HIV positive, please answer the questions below. If HIV negative, skip this page.**

| **When were you diagnosed with HIV?** | **Date:** **State of diagnosis:** |
|---|---|
| How do you think you may have gotten HIV? | Please explain: |
| What is the lowest CD4 count (T-cell) you ever had?<br>What is your latest CD4 count? | □ Lowest CD4 count:<br>□ Last CD4 count:<br>□ Don't know |
| Is your viral load currently undetectable? | □ Yes □ No □ N/A |
| **What is your current HIV medication?** | **Medication:** |
| Who was your HIV provider? (Please provide contact info) | Prior provider info:<br>Name:<br>Address:<br>Phone: |

**Please circle any HIV medications that you were on in the past:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Atripla | Biktarvy | Cabenuva | Cimduo | Complera | Combivir | Delstrigo | Dovato |
| Descovy | Emtriva | Epivir | Epzicom | Edurant | Evotaz | Genvoya | Intelence |
| Juluca | Kaletra | Isentress | Trogarzo | Odefsey | Prezcobix | Prezista | Reyataz |
| Rukobia | Retrovir | Tivicay | Symfi | Triumeq | Temixys | Truvada | Tybost |
| Norvir | Symtuza | Stribild | Symfi Lo | Selzentry | Viread | Vocabria | Ziagen |
| Other meds not listed above: | | | | | | | |

| | |
|---|---|
| Are you allergic to any HIV medications? | □ Yes. If so, which one(s)?<br>□ No |
| Any history of medication resistance? | □ Yes. If so, which one(s)?<br>□ No |

| **Have you had any history of HIV related opportunistic diseases?** | | | **□ No**<br>**□ Yes. If so, please circle below.** | | |
|---|---|---|---|---|---|
| Mycobacterium infection | Tuberculosis | Syphilis | Aspergillosis | Cryptococcosis | Histoplasmosis |
| Cryptosporidiosis | Pneumocystis Carinii Pneumonia (PCP) | Herpes Simplex lasting more than one month | Cytomegalovirus | Herpes Zoster (Shingles) | Prog Mult. Leukoencephalopathy (PML) |
| Cervical Cancer | Lymphoma | Kaposi's Sarcoma | Anal Cancer | Toxoplasmosis | Non-PCP Pneumonia |

## ***Answer these questions if you are a Hepatitis C patient. If not, please skip these questions.***

| Are you seeking Hepatitis C treatment? | □ Yes □ No |
|---|---|
| If yes, have you ever been treated before? | □ No<br>□ Yes, which drug and when? |
| When were you diagnosed? | |
| How did you get exposed? | |
| Do you know your last viral load? | |
| Are you on the liver transplant list? | |
| Do you have Cirrhosis? | □ Yes □ No |

## ***If you are on hormone replacement therapy, answer the questions below. If not, please skip these questions.***

| Are you currently seeking hormone replacement therapy (HRT)? | □ Yes □ No |
|---|---|
| If so, are you currently on HRT? | □ No □ Yes, for how long?<br>Prescribed by whom? |
| Do you have a letter of support? | □ Yes □ No |
| Did you have a legal name change? | □ Yes □ No |
| Are you planning on having any surgery? | □ Yes, please describe.<br>□ No |
| **Have you had any of the following?** | |
| Hysterectomy (Removal of uterus surgery) | □ Yes. Total, or partial hysterectomy?<br>□ No |
| Mastectomy (Breast removal surgery) | □ Yes □ No |
| Orchiectomy (testicular removal surgery) | □ Yes □ No |
| Vaginoplasty | □ Yes, when?<br>□ No |
| Phalloplasty | □ Yes, when?<br>□ No |
| Facial surgery | □ Yes.<br>Name of procedure and when?<br>□ No |
| Total laryngectomy (Voice box surgery) | □ Yes □ No |
| Please describe any surgery not listed above: | |

# 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 Care Center, Inc. to release any information regarding my health to the following persons or entities:

| Name | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Patient's name:________________________________________

Signature:________________________________________ ☐ **Self**

or Relationship to Patient:________________________________

Date: ________/______/________

# 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.)*

- Do you give permission to our office to send you text messages? ☐ Yes ☐ No Initials: _______
- Do you give permission to our office to leave voicemails? ☐ Yes ☐ No Initials: _______
- Do you give permission to our office to send you emails? ☐ Yes ☐ No Initials: _______

Patient's name:_______________________________________________

Signature:_______________________________________________ ☐ **Self**

or Relationship to Patient:_______________________________________________

Date: ________/______/__________

# 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.

Patient's name:______________________________________________

Signature:______________________________________________ ☐ **Self**

or Relationship to Patient:______________________________________________

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.

Patient's name:______________________________________________________________

Signature:__________________________________________________________________ ☐ **Self**

or Relationship to Patient:____________________________________________________

Date: __________/______/___________

# 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

_____I have NOT made such a declaration

**Health Care Surrogate**

_____I have a designated health care surrogate

_____I have NOT designated a health care surrogate

**Durable Power of Attorney**

_____I have appointed a durable power of attorney

_____I have NOT appointed a durable power of attorney

Patient's name:______________________________________________

Signature:______________________________________________ ☐ **Self**

or Relationship to Patient:______________________________________________

Date: _________/_______/___________

# 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 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.

Patient's name:______________________________________________

Signature:______________________________________________ ☐ **Self**

or Relationship to Patient:______________________________________________

Date: ________/______/__________

| | Michael E. Dunn, MD, AAHIVS<br>Rodrigo Sabec, APRN, FNP<br>Michael Cooley, APRN, AGNP-C<br>• **3317 W Gandy Boulevard**<br>**Tampa, FL 33611**<br>• **5224 East Fowler Avenue**<br>**Temple Terrace, FL 33617**<br>*Ph:(813) 902-8600*<br>*Fax:(877) 231-7263*<br>*www.midwaycare.org* |
|---|---|

# Authorization for Release of Medical Records

I hereby request and authorize release copies of my medical records to Midway Specialty Care Center, Inc.

Records can be sent to the address above

I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorized the release of the following to Midway Specialty Care Center, Inc.

Type of information to be disclosed:

| | | |
|---|---|---|
| □ Entire medical record | □ Radiology reports | □ All Hospital records |
| □ Consultation | □ Billing statements | □ Discharge summary |
| □ Dental records | □ Pathology reports | □ Laboratory reports |
| □ Office chart notes | □ Emergency Department reports | □ Other: |

In addition, I authorize, and I am aware that this information may include health information relating to (check if applicable):

| | | | |
|---|---|---|---|
| □ HIV/AIDS Infection | □ Drug/Alcohol Abuse | □ Genetic Test | □ Psychiatric |
| | | | |
| Patient Name: | | | DOB: |
| Patient's Signature | | | Date: |
| Last 4 digits of social: | | (FOR OFFICE USE ONLY) Expiration Date: | |