MIDWAY
SPECIALITY CARE CENTER

NEW PATIENT QUESTIONNAIRE

Date: _____

A. DEMOGRAPHICS

Name: _____ DOB: _____ Social Security Number _____
Street Address: _____City: _____ Zip: _____
How long have you lived at the above address? _____
Telephone Numbers: Home _____ Cell _____ Work _____
Gender: Male _____ Female _____ Transgender _____ Relationship Status:
_____
What date (or approximate date) were you diagnosed with HIV? _____
How did you acquire HIV? _____

B. SEXUAL HISTORY

Sexual Orientation: Heterosexual _____ Homosexual _____ Bisexual _____
Are you sexually Active? Yes _____ No _____ Have you had sex in the past 12 months? Yes _____ No _____
With: Men only _____ Women only _____ Both Men and Women _____
Used Protection: Yes _____ No _____
Prevention Strategies: Abstinence _____ Condoms _____ Other _____
Have you ever had an STD (sexually transmitted disease)? Yes_____ No _____
Please circle: Chlamydia GC Syphilis Herpes Other: _____
For females, what was the date of your last menstrual period? _____
How many sexual partners have you had? _____
Sexual Practices: Vaginal _____ Anal _____ Oral _____
Do you use condoms or some type of barrier protection? Yes _____ No _____
How often do you use protection? Always _____Sometimes _____Never _____
What type of protection do you use? _____

C. OTHER RISK FACTORS

Have you ever been in jail? Yes _____ No _____
Have you ever had a blood transfusion? Yes _____ No _____
Have you traveled outside of the country Yes _____ No _____ If yes, where and when? _____

D. SUBSTANCE USE

Please circle one:
Current smoker:_____ Former smoker:_____ Non-smoker:_____
Light tobacco smoker: _____ Heavy tobacco smoker:_____ Uses tobacco in other forms_____

D. SUBSTANCE USE (CONT'D)

Do you have a history of drug or alcohol abuse? Yes _____ No _____
Do you use street drugs? Yes _____ No _____ If yes, what type? _____
Do you have a history of using IV drugs? Yes _____ No _____ If yes, what type? _____
Do you drink alcohol? Yes _____ No _____ If yes, how much?
If yes, how many drinks did you have on a typical day when you were drinking in the past year?
_____ 1 or 2 drinks
_____ 3 to 4 drinks
_____ 5 to 6 drinks
_____ 7 to 9 drinks
_____ 10 or more drinks
If yes, how often did you have 6 or more drinks on one occasion in the past year?
_____ Never
_____ Less than monthly
_____ Monthly
_____ Weekly
_____ Daily or almost daily
Do you drink coffee? Yes _____ No _____ If yes, how many cups per day? _____
What type of diet do you follow? _____

E. SOCIAL HISTORY

What is your employment status?
_____ Currently employed _____ Unemployed, but seeking work _____ Unemployed
_____ Disabled/not working _____ Employed part-time _____ Student
Circle all that apply to you:
Single Significant Other Married Legally Separated Divorced Widowed
Do you live alone? Yes _____ No _____ If no, with whom do you live? _____
Does your family know about your HIV status? Yes _____ No _____
If no, have you told anyone? Yes _____ No _____
Do you have any pets? Yes _____ No _____ If yes, what kind? _____

F.* HIV TREATMENT HISTORY **Please skip this section if you are newly diagnosed with HIV

Do you recall your CD4 and/or Viral Load at diagnosis? _____

What is the lowest your Absolute CD4 count has been in the past? _____

Please list your current HIV medications: _____

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

Genvoya	Triumeq	Complera	Isentress	Prezista	Prezcobix
Norvir	Descovy	Epzicom	Epivir	Ziagen	Sustiva
Selzentry	Stribild	Atripla	Odefsey	Tivicay	Evotaz
Reyataz	Tybost	Truvada	Emtriva	Viread	Edurant
Intelence	Aptivus	Juluca	Crixivan	Symtuza	Invirase
Kaletra	Lexiva	Rescriptor	Retrovir	Trizivir	Biktarvy
Viracept	Viramune XR	Zerit	Other: _____		

Are you allergic to any HIV medications? Yes _____ No _____ If yes, which ones: _____
_____

F. HIV TREATMENT HISTORY (CONT'D)

Have you had any history of HIV related opportunistic infections? Yes _____ No _____ If yes, which ones:

Mycobacterium Infection	Tuberculosis	Syphillis/Neurosyphillis		Aspergillosis
Cryptococcosis	Histoplasmonia	Pneumocystis Carinini Pneumonia		Non-PCP Pneumonia
Herpes Simplex lasting more than 1 month		Herpes Zoster (Shingles)		Cytomegalovirus
Kaposi's Sarcoma	Anal Cancer	Cervical Cancer	Lymphoma	Toxoplasmosis

Other: _____

G. OTHER MEDICAL HISTORY/TREATMENT

Do you have any drug allergies? Yes _____ No _____ If yes, please list: _____

_____

_____

Please check any of the symptoms you are currently experiencing?

Symptom	Yes	No	Symptom	Yes	No
General Constitutional			**Respiratory**		
Fever			Cough		
Night sweats			Hemoptysis		
Sudden weight loss or gain			Shortness of breath		
Gastrointestinal			Wheezing		
Abdominal pain			**Genitourinary**		
Constipation			Blood in urine		
Diarrhea			Difficulty urination		
Heartburn			Frequent urination		
Nausea			Painful urination		
Vomiting			Pain in lower back		
Poor appetite			Vaginal or Penile discharge		
Difficulty swallowing			Genital/Rectal warts or ulcers		
Blood in stool or hemorrhoids			**Musculoskeletal**		
Cardiovascular			Loss of strength		
Dizziness/Syncope			Muscle pain		
Lower extremity edema			Joint pain		
Chest pain			Cramping		
Palpitations			**Neurological**		
ENT			Tingling/ burning/numbness/pain extremities		
Hearing Loss			Frequent headaches or migraines		
Change in Vision			Focal weakness		

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

_____

_____

OTHER MEDICAL HISTORY/TREATMENT (Cont'd.)

Do you or your family members have any history of the following medical conditions: ***(Please check all that apply)***

Health Condition	Self	Mother	Father	Sibling	Health Condition	Self	Mother	Father	Sibling
Alcoholism					High Blood Pressure				
Anemia					Kidney Disease				
Bleeding Disorder					Mental Illness				
Cancer					Headaches/Migraines				
Diabetes					Osteoporosis				
Epilepsy/Convulsions					Stroke				
Glaucoma					Thyroid Disease				
Hair Loss					Heart Disease				
Lung Disease					High Cholesterol				
Prostate/Cervical					Seizure Disorder				
Neuropathy					Back Problems				

Have you had any of the following sexually transmitted diseases?
Syphilis Yes _____ No _____
Gonorrhea Yes _____ No _____
Venereal Warts Yes _____ No _____
Genital Herpes Yes _____ No _____
Chlamydia Yes _____ No _____
Do you have Hepatitis B? Yes _____ No _____ Unknown _____
Do you have Hepatitis C? Yes _____ No _____ Unknown _____
If yes, have you been treated for Hep C? Yes_____ No_____ Date(s) you were treated:_____
& Medication:_____

VACCINATION HISTORY:

Please list the date you last received the following immunizations, if applicable:
Flu Shot _____ Pneumonia Vaccine _____
Hep A Shot _____ Hep B Shot _____ Tetanus Shot _____
Date of last PAP Smear, if applicable: _____ Last mammogram: _____
Date of last PPD (test for tuberculosis): _____ Have you ever had a positive PPD? Yes_____ No _____
Date of last eye exam: _____ Date of last dental exam: _____ Last chest X-ray: _____
Have you ever had a colonoscopy? Yes _____ No _____ If yes, when? _____
Please list all past surgical procedures: _____
_____
Please list all past in-patient hospitalizations and reason for admission:

Date **Reason for Admission**

_____ _____
_____ _____
_____ _____

MENTAL HEALTH/PSYCHIATRIC HISTORY

Have you ever been diagnosed with a psychological disorder? Yes _____ No _____
If yes, what was the diagnosis? _____
If yes, please describe treatment (i.e. counseling, medications, etc.) _____
_____

Are you currently seeing a psychiatrist or therapist for MH treatment? Yes _____ No _____

If yes, who are you seeing? _____
Have you ever tried to commit suicide? Yes _____ No _____ If yes, what year? _____

H. MENTAL HEALTH/PSYCHIATRIC HISTORY (CONT'D)

Please circle any of the following symptoms you may have experienced in the past (30) days:

Sadness	Hopelessness	Sleeping too Much	Fatigue	Hearing Things
Lack of Interest	Feeling Worthless	Not enough sleep	Restlessness	Too much energy
Irritable	Impulsive	No need for sleep	Poor Memory	Can't concentrate
Anxious	Fearful	Panic Attacks	Suspicious	
Seeing Things	Intense Anger/Rage	Nightmares	Difficulty being in Crowds	

Do you have handguns or any other weapons in your home? Yes _____ No _____

Please list all medications you are currently taking (excluding HIV medications):

Medication	**Dosage**	**How Long?**	**Prescribed by:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature _____ Date_____

MIDWAY
SPECIALTY CARE CENTER

Moti Ramgopal, MD, FACP, FIDSA, CPI
Darla Bagwell, ARNP, AAHIVS
Lauren Leeflang, PA-C
356 E Midway Road
Fort Pierce, Fl 34982
Ph: (772) 464-9746 Fax: (772) 464-9750

When registering in our office, please present your insurance cards, any forms (completed and signed) and your referral if you have HMO insurance.

Patient's Name (First/Middle/Last):	Social Security #:	DOB (MM/DD/YYYY):	Age:	Marital Status: S M W D Sep	Gender: M / F
Address:	City & State:	Zip Code:	Home Phone: ( )		
Email Address:			Cell Phone: ( )		
Employer:		Occupation:			
Employer Address:	City & State:	Zip Code:	Business Phone: ( )		

If patient is a minor or student, please complete below:

Mother's Name(First/Middle/Last):	Mother's SS#:	Mother's DOB:	Mother's Employer:
Mother's Employer's Address:	City & State:	Zip Code:	Business Phone: ( )
Father's Name(First/Middle/Last):	Father's SS#:	Father's DOB:	Father's Employer:
Father's Employer's Address:	City & State:	Zip Code:	Business Phone: ( )

Name of Family Doctor:	Name of Referring Doctor	
Emergency Contact:	Phone: ( )	Relationship

Please complete insurance information on next page.

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HEALTH	Name of Primary Insurance:	Address of Company:	
	ID Number:	Group Number:	
	Name of Subscriber to Insurance:	Subscriber's SS#	Subscriber's DOB:
	Name of Secondary Insurance:	Address of Company:	
	ID Number:	Group Number:	
	Name of Subscriber to Insurance:	Subscriber's SS#	Subscriber's DOB:
RX	Name of RX Insurance:	ID Number: RX Group Number:	
	Address of Company: Phone Number:	RX Bin Number: RX PCN Number:	
INJURY	Work (Company): Name of Auto : Name of Lawyer:	Date of Injury :	
	Claim Number : Phone Number:	Address:	

Please Read: All charges are payable at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

All professional services rendered are charged to the patient. Necessary forms will be completed 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 with our Billing Department.

Insurance Authorization and Assignment

I hereby authorize Midway Specialty Care Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Midway Specialty Care Center 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.

Please be aware that if you have an HMO Plan a referral must be obtained from your Primary Care Provider for each of your visits. If one is not obtained, you will be held fully responsible for all charges.

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Signature :_____ Date:_____

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. Testing includes but is not limited to physical, radiological, and laboratory testing. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I consent to allow my laboratory testing specimens (including but not limited to blood, urine, or sputum samples) to be processed in-house (by MSCC/lab) or sent out to a reference lab as deemed necessary by Midway Specialty Care Center, Inc. I also understand that my specimens may be used for validation purposes.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient (or Personal Representative)_____ Date_____

Printed Name of Patient (or Personal Representative)_____Relationship _____

Printed Name of Witness: _____Employee Job Title _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain 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 health care 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 Name: _____

Relationship to Patient: _____

Signature: _____

Date Signed: _____

OFFICIAL USE ONLY

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

Initial: _____ Date: _____

Reason: _____

MIDWAY
SPECIALTY CARE CENTER

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

In accordance with Act, I _____ (patient name) hereby authorize Midway Specialty Care Center to release any information regarding my health to the following persons or entities:

_____
_____
_____
_____
_____
_____

In the event that I am not home when Midway Specialty Care Center calls with medical information:

_____ Please **DO** leave messages on my answering machine

_____ Please **DO NOT** leave messages on my answering machine

_____ I **DO NOT HAVE** an answering machine

Patient Name _____

Patient Signature _____ Date _____

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External Prescription History

Name _____ DOB _____

_____ I give consent for Midway Specialty Care Center to review my external prescription fill history.

_____ I DO NOT give consent for Midway Specialty Care Center to review my external prescription fill history.

Signature _____ Date _____

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SPECIALTY CARE CENTER

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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.

Provider of records being requested:_____ Tel:_____
Address of provider:_____ Fax:_____

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	□Substance Abuse (EtOH, drugs)	□ Genetic Test	□ Psychiatric
Patient Name:			DOB:
Patient's Signature			Date:
Last 4 digits of social:		(FOR OFFICE USE ONLY) Expiration Date:	