



Dear Patient:

The following questions are designed to collect important information about you and your health. Answering these questions before your office visit will allow more time for a detailed discussion with your provider. Please complete all questions.

PATIENT INFORMATION & PREFERENCES *(Please print or type)*

Last Name: _____ First Name: _____ M.I. _____

Preferred Name: _____ Date of Birth: ____/____/____

Primary Insurance: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Number: _____

YOUR MAJOR HEALTH CONCERNS OR QUESTIONS

What matters most to you about your health? _____

Describe briefly the major medical problem(s) or question(s) that you have: _____

List below all the medications that you take regularly or have taken regularly in the past month (including aspirin products, vitamins, birth control pills, etc.):

Drug	Drug Strength	How often you take the drug each day	Length of time you have taken the drug



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Patient Name (Print): _____ Patient DOB: ____/____/____

Do you need medication refills today? ☐ Yes ☐ No If yes, please list below:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Are you having problems affording your medications? ☐ Yes ☐ No

Allergies: List any drug allergies (if any, briefly describe the reaction): _____

Are you allergic to antibiotics (such as penicillin or sulfa)? ☐ Yes ☐ No

Please answer the following questions regarding your Sexual Orientation and Gender Identity:

Birth Sex: ____ Male ____ Female ____ Unknown

What is your Gender Identity:

____ Male ____ Female

____ Female-to-Male (FTM) /Transgender Male/Trans Man ____ Male-to-Female (MTF) / Transgender Female/Trans Woman

____ Genderqueer, neither exclusively male nor female ____ Other: _____

____ Choose not to disclose

What is your Sexual Orientation:

____ Lesbian, gay, or homosexual ____ Straight or heterosexual ____ Bisexual

____ Do not know ____ Choose not to disclose ____ Other: _____

What is your current relationship status?

____ Single ____ Partner ____ Married

Please place a check mark next to the highest level of education you obtained in school:

____ Elementary ____ High School ____ College ____ Other: _____

How do you prefer to learn new information? (circle one)

Doing / Demonstration

Reading / Written Materials

Watching / Video or Presentations



Patient Name (Print): _____

Patient DOB: ____/____/____

PAST MEDICAL HISTORY

Place a check mark on the line next to the illness or illnesses that you currently have or have had in the past:

____ Anemia	____ Gallstones	____ Kidney stones
____ Arthritis	____ Glaucoma	____ Liver disease
____ Asthma	____ Gout	____ Nervous stomach
____ Cancer	____ Heart attack	____ Rheumatic fever
____ Cirrhosis	____ Heart trouble	____ Spastic colon
____ Depression or other mental illness	____ Hepatitis	____ Stomach ulcers
____ Diabetes	____ High blood pressure	____ Thyroid trouble
____ Emphysema	____ Kidney infections	____ Yellow jaundice

Serious past injuries (describe the type of injury and approximate dates of occurrences):

Previous surgery (Place a check mark on the short line next to the type of surgery you have had. On the long line, indicate the approximate date of surgery.):

____ Appendix _____	____ Hemorrhoids _____
____ Breast surgery _____	____ Hysterectomy _____
____ Eye surgery _____	____ Open heart surgery _____
____ Gallbladder _____	____ Stomach or colon surgery _____
____ Other surgery: _____	

Previous hospitalizations (other than surgery):

Hospital	Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Patient Name (Print): _____

Patient DOB: ____/____/____

HEALTH MAINTENANCE

Vaccines

When was your last tetanus booster? _____

Have you had a flu (influenza) vaccine in the last 12 months? ☐ Yes ☐ No

If yes, please tell us when and where, if known: _____

Have you had a pneumonia vaccine in the last 12 months? ☐ Yes ☐ No

If yes, please tell us when and where, if known: _____

Have you ever had a shingles vaccine? ☐ Yes ☐ No

If yes, please tell us when and where, if known: _____

Screenings

Do you have eye exams regularly? ☐ Yes ☐ No Where and when was your last eye exam? _____

Do you have dental exams regularly? ☐ Yes ☐ No Where and when was your last dental exam? _____

Have you ever had a colorectal cancer screening (colonoscopy)? ☐ Yes ☐ No

If yes, please tell us when and where, if known: _____

What is your usual weight? _____ What was your approximate weight one year ago? _____ What is your present weight? _____

WOMEN:

Name and address of your GYN Provider: _____

Have you had a "Pap" smear in the last two years? ☐ Yes ☐ No

Have you ever had a Mammogram? ☐ Yes ☐ No If yes, where and when was your last scan? _____

Have you ever used birth control pills? ☐ Yes ☐ No

Obstetrical History: Number of pregnancies: _____ Number of deliveries: _____

Please tell us about any other Specialists you see: List the name, location, and how often you see them:



Patient Name (Print): _____

Patient DOB: ____/____/____

FAMILY HISTORYIs your mother living? ☐ Yes ☐ No (cause of death and age at death _____)Is your father living? ☐ Yes ☐ No (cause of death and age at death _____)

Have any family members, either living or dead, ever had any of the following diseases? If yes, place a check mark on the short line next to the illness. On the long line next to the illness, put the name of the family member or the initial code letter of the family member that had the illness. The following code initials may be used:

Mother [M]

Brother [B]

Aunt [A]

Father [F]

Child [C]

Uncle [U]

Sister [S]

Grandparent [GP]

Cousin [CS]

(For example: If one of your grandparents and a cousin had tuberculosis: ☒ Tuberculosis GP, CS)**Family Member**

____ Alcoholism _____

____ Cancer _____

____ Breast cancer _____

____ Colon cancer _____

____ Ovarian cancer _____

____ Colitis _____

____ Diabetes _____

Family Member

____ Heart Attack _____

At what age(s)? _____

____ High blood pressure _____

____ Kidney disease _____

____ Osteoporosis _____

____ Tuberculosis _____

____ Other _____

SOCIAL HISTORY AND HABITSDo you drink alcoholic beverages (wine, beer, liquor, etc.)? ☐ Yes ☐ No

If yes, how many alcoholic beverages do you have on average in a week? _____ per week

Do you smoke? ☐ Yes ☐ NoIf no, have you ever smoked? ☐ Yes ☐ No

Please tell us how many years you have/had been a cigarette smoker: _____ year(s)

Have you ever tried to quit smoking? ☐ Yes ☐ No

How many days per week do you exercise for at least 20 minutes? _____ days per week

Are you sexually active? ☐ Yes ☐ No

What method of contraception do you use?

____ Birth control pill

____ Condom

____ Diaphragm

____ Other: _____

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No



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ASSIGNMENT OF INSURANCE BENEFITS

Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Coastal Medical, I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY MY BENEFIT PLAN.

Patient's
Signature

_____/____/____
Date

Have you designated anyone to function as your legal guardian or decision maker (by completing a "living will" or "power of attorney" form) in the event that you are unable to make decisions regarding your health care?

☐ Yes ☐ No

If "YES," please write the name, address, phone number, and relationship of that individual:

Name: _____

Address: _____

Relationship to you: _____ Phone: _____

If "NO," please ask your physician about this.

I have reviewed the information in this questionnaire and verified that the information is accurate.

Patient's Signature

If questionnaire was completed by someone other than the patient:

Relationship to patient: _____

Patient's signature

PHYSICIAN'S NOTES:



CONTACT INFORMATION FORM

Patient Name: _____ **DOB:** ____ / ____ / ____

Emergency Contact Information

Please complete all information below. In the event of an accident or other emergency, we will use this information to notify your preferred contacts:

Primary Contact Person:

Name: _____ DOB: ____ / ____ / ____

Relationship to patient: _____

Are they a Coastal Medical Patient: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Contact Person:

Name: _____ DOB: ____ / ____ / ____

Relationship to patient: _____

Are they a Coastal Medical Patient: ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Permission to Discuss

I, the undersigned, hereby give Coastal Medical permission to discuss my medical information with:

Name #1: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name #2: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list any exclusions to discuss such as AIDS, HIV, psychiatric disorders, history of treatment for drug or alcohol abuse:

Patient/Legal Guardian Signature: _____

Date: ____ / ____ / ____

You may update this information at any time.



For status inquiries: Patients should call 978.922.0016 Attorneys and Insurance Companies should call 858.244.1811

Authorization to Use or Disclose Protected Health Information

Patient Name _____ DOB _____ Phone _____

Address _____
Street City State ZIP

1. I hereby authorize (Please check all that apply):

- ☐ Rhode Island Hospital/Hasbro Children's ☐ Brown Health Medical Group, Inc.
☐ The Miriam Hospital ☐ Brown Health Medical Group
☐ Newport Hospital ☐ Primary Care

2. To release to:

Person /Place/ Institution

Street City State Zip Phone

3. Dates of treatment or time period _____

4. Purpose for which disclosure is to be made: ☐ Coordination of Care ☐ Patient Request ☐ Legal

☐ Other (please specify): _____

5. Record Format-please check one: ☐ paper ☐ CD disc

6. Information to be disclosed (check all applicable): There may be a fee associated with this request

☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab/X-ray Reports ☐ Other Diagnostic Testing

☐ Clinic/Office Visit ☐ Consultation / Evaluation ☐ After Visit Summary

☐ Abstract* ☐ Discharge Summary ☐ Other _____

*Abstract includes: Facesheet, ED Record, H & P, D/C Summary, Consult, Operative report, Pathology report, test results, PT / OT / ST

For Behavioral Health Requests: ☐ Assessment ☐ Treatment Plan ☐ Psychiatric Evaluation ☐ Medications

7. I do not want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test

☐ sexual abuse ☐ sexually transmitted infections ☐ AIDS/HIV test results

8. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.

9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Brown University Health, its employees and my physicians from all liability arising from this disclosure of my health information.

10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Brown University Health in writing. I understand that any previously disclosed information would not be subject to my revocation request.

11. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

Signature of Patient*, Legal Guardian, or Representative Date/Time

Print name of Patient, Legal Guardian or Representative Date/Time

*Note Concerning Minors: For disclosures to persons / entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV & venereal disease) or for alcohol and/or drug abuse treatment is required.