BAY AREA FAMILY PRACTICE
HEALTH HISTORY
(Confidential)

NAME: _____ TODAY'S DATE: _____

AGE: _____ BIRTHDATE: _____ DATE OF LAST PHYSICAL EXAMINATION: _____

WHAT IS YOUR REASON FOR THIS VISIT: _____

SYMPTOMS Check (✓) Symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hands
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorroids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing ears
- ☐ Sinus problems
- ☐ Vision - flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Score is penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other:
- Date of last -
- Mestrual period / /
- Pap smear / /
- Have you had a Mammogram? Y N
- Are you pregnant?
- Number of children

CONDITIONS Check (✓) if you have or have had in the past.
- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulemia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medictions you are currently taking

ALLERGIES to medications and substances

Pharmacy Name: Phone #:

(All information is strictly confidential)

Family History Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes _____ No _____

If yes, please give appropriate dates: _____

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications, if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use

	Caffeine
	Tobacco
	Drugs
	Other

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

1. Do you eat away from your home? _____ Yes _____ No If yes, how many times per week? _____
   Where? _____
2. Do you engage in physical activity? _____ Yes _____ No If no, why not? _____
   If yes, how frequently? 30 mins/day _____ 1 - 2 times / week _____
   3 - 4 times / week _____ 5 - 6 time / week _____
3. Do you feel safe at home? Yes _____ No _____ If no, why? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature _____ Date

_____ Reviewed by _____ Date

Bay Area Family Practice PA **Salma Tabrez MD**

Patient Registration Form

Patient's Name	**Birth Date**
Local Address	Telephone
	Sex M F
City State Zip	
Social Security No.	Do you have a living will? Y N
Drivers License No.	
Employer's Name or Second address if applicable	
Address	
City State Zip	
Telephone No.	
Spouse/Responsible Party	
Name	Home Phone
Employer's Name	Work Phone
Address	Social Security No.
City State Zip	Birth Date
Emergency Information	**Name of Nearest Relative (not living with you)**
Name	Home Phone
Address	Work Phone
City State Zip	Relationship
Primary Insurance	**Secondary Insurance**
Insurance Company	Insurance Company
Phone	Phone
Address	Address
I.D # or SSN	I.D # or SSN
Group Name or No.	Group Name or No.

Consent Information Release/ Payment Agreement:

I herby consent to Bay Area Family Practice PA to provide whatever treatment may be necessary to the patient. I authorize them to release appropriate information concerning my care for billing purposes to Medicare, Medicaid or any other insurance carrier. I understand that it is mandatory to notify the healthcare provider or any other party who may be responsible.

Professional services rendered are changed to the Medicare or other insurance carriers. However, the patient is ultimately responsible for all fees, regardless of insurance coverage. Payment/deductibles or co-payment is due at the time of service, unless prior arrangements have been made. Bay Area Family Practice PA will not be responsible for paying hospital bills, outside labs, pathology reports, x-ray readings, etc. that may be incurred for your care during your office visit. Patient authorizes Bay Area Family Practice PA to obtain any information necessary to establish credit for services rendered, but not limited to credit bureau reports.

Patient or Responsible Party's Signature _____ **Date** _____

Bay Area Family Practice, PA Family & Friends Consent Form

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In Emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP) and other doctors/specialist) with whom we may share your information:

Name	Contact Number

What is the best phone number for us to contact you? _____

What is this number (Home, Cell, Work)? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voicemail, or with another individual in your absence. Is it OK for such messages to include details (such as diagnosis and medication information) at this number? _____

_____ _____

Signature of Patient or Legal Representative

Printed Name of Patient or Legal Representative

_____ _____

Date of Birth

SSN Number

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Bay Area Family Practice, P.A creates and maintains health records and other information describing, among other things, my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing , except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restriction writing on the use and disclose of my Protected Health Information which have been previously agreed upon.

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature (or guardian, if a minor) SSN. (For identification purposes)

No Show & Cancellation Policy
For Bay Area Family Practice, P.A.

Patient Name:_____ Date of Birth:_____

Dear Patient,

Effective immediately, Bay Area Family Practice, has instituted a formal policy regarding cancellations and "no shows". A "now show" is defined as a scheduled appointment that the patient does not keep. Patients are expected to call to cancel if they can not make a scheduled appointment.

No Shows:

First occurrence: Patient will be sent a letter or called. No fine is assessed.

Second occurrence: Patient will be charged a $25 fee.

Third occurrence: Patient will be charged a $50 fee. Patient may be discharged from the practice. The decision whether or not to discharge you will be at your doctor's discretion.

**** Any additional "no shows" the patient will be charged the full price of the scheduled office visit ****

Cancellations:

Routine Appointments: (e.g. Blood pressure visits, colds, back pain) should be cancelled at least 4 hours before the scheduled appointment time. Any appointments cancelled less than 4 hours before the scheduled appointment time will be treated as a "no show"

Complete Physical Exams or Pre-Operative Clearances: should be cancelled at least 24 hours prior to the scheduled appointment time. Any appointments cancelled less than 24 hours prior to the scheduled appointment time will be treated as a "no show"

Other Notes:

Any "no show" appointment that had occurred prior to the institution of this policy (January 1, 2007) will be counted towards your "no show" totals. If you want to inquire about whether you have "no showed" in the past, you can inquire with your medical assistant at your next visit. We apologize for the need of this policy. Unfortunately we've had too many patients abusing our existing policy.

_____ _____ _____

Signed Date Witnessed

COVID-19 Pandemic Patient Consent Form

I _____ (Patient) knowingly and willingly have consented to having an in-person consultation (Service) with Dr. Salma Tabrez and her staff during the COVID-19 Pandemic at Bay Area Family PA (Office).

___ (Initial) I understand the COVID-19 virus has a long treatment and recovery period during which those infected may not show symptoms and could still be contagious. It is nearly impossible to know who is infected given our current limits of virus testing.

___ (Initial) I represent that I am not presenting any of the following symptoms of COVID-19 listed below (symptoms from the Center for Disease Control and Prevention(CDC)):

Fever	Cough
Chest Pain	Shortness of Breath
Diaherra	Muscle or Body Aches
Fatigue	Headache
New Loss of Taste or Smell	Sore Throat
Congestion or Runny Nose	Nausea or Vomiting

___ (Initial) To keep both myself and the Office's physician and staff safe and prevent the spread of COVID-19, I will strictly follow the Office's guidelines. I also am aware that I must follow the CDC and Occupational Health and Safety Administration recommended social distancing of AT LEAST 6 feet.

___ (Initial) I am aware and understand that air travel increases my risk of contracting and transmitting the COVID-19 virus.I represent that I have not traveled outside of the United States in the past 14 days, nor have I traveled domestically within the United States by airlines, buses, or trains within the past 14 days.

___ (Initial) I acknowledge and agree that I understand the risks associated with obtaining the Service during the current COVID-19 pandemic. I hereby waive, release, and discharge the Office, physician, and staff members from ALL claims and liability in relation to the COVID-19 pandemic.

_____ _____

Patient Date (mm/dd/yyyy)

COVID-19 Pandemic Individual Accompanying the Patient