SOUTH SHORE MEDICAL CARE, P.C.

HEALTH HISTORY FORM

BIRTHDATE _____/_____/_____ PATIENT NAME _____

To help us meet all of your healthcare needs, please fill out both sides of this form in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date _____
Place of birth_____
Highest Level in School_____
Occupation_____
Previous Occupations_____
Marital Status_____
Hobbies_____
Exercise, recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type & amount per week)_____
Caffeine (type & amount per week)_____
Street drugs (type & amount per week)_____
Usual Weight_____
Date if last dental exam_____
Please list all allergies (food, drugs, environment)
_____
_____
_____

When was your last Physical Exam?_____
Name of Doctor_____ Phone _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate where these occurred:
☐ None
_____
_____
_____

Please list all medicines you are currently taking (include non prescription drugs:
☐ None
_____
_____
_____

Describe all serious accidents, severe injuries, head injuries, fractures or broken bones (include date occurred): ☐ None
_____
_____
_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing.
_____
_____

PAST MEDICAL HISTORY

Have you ever had the following? *(Circle "no" or "yes", leave blank if uncertain)*

Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Mitral Valve Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes	Transfusions	no	yes	Kidney Disease	no	yes
Heart Disease	no	yes	Back Trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low B/P	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes	Hemorrhoids	no	yes	Any other disease:		
Anemia	no	yes	Date of last chest x-ray_____			_____		
Epilepsy	no	yes	Asthma	no	yes	_____		

FAMILY HISTORY

Has any blood relative had any of the following? (*Circle "no" or "yes", leave blank if uncertain)*

Cancer	no	yes	Stroke	no	yes	Asthma	no	yes
Tuberculosis	no	yes	Epilepsy	no	yes	Chronic lung disease	no	yes
Diabetes	no	yes	Allergies	no	yes	Drug or alcohol problem	no	yes
Heart Disease	no	yes	Anemia	no	yes	Mental Illness	no	yes
High Blood Pressure	no	yes	Bleeding tendency	no	yes	Leukemia	no	yes

FAMILY HISTORY (Cont.)

(Circle "no" or "yes", leave blank if uncertain)

Migraine headaches	no	yes
Obesity	no	yes
Thyroid Disease	no	yes
Ulcer	no	yes
Depression	no	yes
High Cholesterol	no	yes
Kidney Disease	no	yes
Glaucoma	no	yes
Gout	no	yes

Relationship	Present age, or age of death	If living, health (good, poor) If deceased, cause of death
Father		
Mother		
Siblings		
Spouse		
Children		

Do you have now or have you had within the past year? (Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes	Bloody sputum	no	yes	Joint pain or stiffness	no	yes
Tire easily or weakness	no	yes	Wheezing	no	yes	Swollen joints	no	yes
Recent weight change	no	yes	Chest pain or discomfort	no	yes	Muscle cramps or spasms	no	yes
Change in appetite	no	yes	Purple fingers	no	yes	Sleeplessness	no	yes
Sensitivity to cold or heat	no	yes	Swelling of hands, feet, ankles	no	yes	Seizures	no	yes
Persistent fever	no	yes	Difficultly in breathing	no	yes	Depression	no	yes
Night sweats or hot flashes	no	yes	Palpitations	no	yes	Memory loss	no	yes
Skin rash	no	yes	Leg cramps	no	yes	Poor coordination	no	yes
Skin trouble or changes	no	yes	Enlarged veins	no	yes	Dizziness or fainting	no	yes
Change in nails or hair	no	yes	Difficulty swallowing	no	yes	A living or advance directive	no	yes
Headaches	no	yes	Heartburn	no	yes	**MEN ONLY:**		
Easy bleeding or bruising	no	yes	Frequent belching	no	yes	Discharge from penis	no	yes
Double vision	no	yes	Abdominal cramping	no	yes	Pain or lump in testicles	no	yes
Eye pain	no	yes	Nausea	no	yes	Impotence	no	yes
Infected eyes	no	yes	Vomiting	no	yes	**WOMEN ONLY:**		
Do you wear glasses or contacts	no	yes	Vomited or coughed up blood	no	yes	Age period began _____		
When was your last eye exam? _____			Chronic diarrhea	no	yes	How many days do periods last? _____		
Ringing in ears	no	yes	Chronic constipation	no	yes	How many days between periods? _____		
Discharge from ears	no	yes	Rectal bleeding	no	yes	Is the flow heavy?	no	yes
Ear pain	no	yes	Black tarry stools	no	yes	Do you bleed or spot		
Decrease in hearing	no	yes	Dark urine	no	yes	between periods?	no	yes
Frequent nosebleeds	no	yes	Yellow jaundice	no	yes	Do you have pain or cramps	no	yes
Frequent colds	no	yes	Frequent urination (day)	no	yes	Date of last period _____		
Sinus trouble	no	yes	Frequent urination (night)	no	yes	Date of last pelvic exam _____		
Loss of smell	no	yes	Increase in thirst	no	yes	Date of last mammogram _____		
Persistent hoarseness	no	yes	Painful urination	no	yes	Any itching in vaginal area	no	yes
Sore throat	no	yes	Leakage of urine	no	yes	Pain with intercourse	no	yes
Sore tongue or gums	no	yes	Difficulty in starting urine	no	yes	Type of birth control used _____		
Lump or discharge from breast	no	yes	Blood in urine	no	yes	Number of pregnancies _____		
Chronic or frequent cough	no	yes	Hemorrhoids	no	yes	Number of full-term births _____		
Shortness of breath	no	yes	Backaches	no	yes	Number of pre-term births _____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

_____ _____

Signature of patient or parent if minor Date

South Shore Medical Care P.C.
16 Van Cott Rd. Suite 2E Deer Park NY 11729
Phone: (631) 274-0777
Fax: (631) 274-9499

Marc A. Lewandoski, D.O., F.A.C.O.F.P, M.R.O.
Lauren Bovelle, PA-C
Maciej Mazurkiewicz, PA-C

PATIENT INFORMATION:

First name:_____ **Last name:**_____

Address:_____
City:_____ **State:**_____ **Zip:**_____

E-Mail:_____

Sex: **Male** **Female** **DOB:**_____

Marital status: **Single** **Married** **Divorced** **Widowed**

Home Phone #_____ **Cell #**_____

Work #: _____ **Social Security #:**_____

Pharmacy:_____ **Phone:**_____

Pharmacy address:_____

EMPLOYER INFORMATION:

Occupation:_____ **Employer name:** _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

PRIMARY INSURANCE:

Insurance company:_____ **ID #:**_____

Name of insured:_____ **DOB:**_____

Relationship to insured: **Self** **Spouse** **Child** **Other**

SECONDARY INSURANCE:

Insurance company:_____ ID #:_____

Name of insured:_____ DOB:_____

Relationship to insured: Self Spouse Child Other

EMERGENCY CONTACT:

Name:_____ Relationship:_____

Cell:_____ Home:_____

PATIENT AUTHORIZATION:

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize the release of medical information pertaining to medical treatment as requested by my health insurance carrier or the health care financing administration and its agencies for determination of benefits coverage.

_____ _____

Patient signature Date

AUTHORIZATION TO PAY INSURANCE BENEFITS:

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize payment directly to the above named physician or his billing organization, otherwise payable to me but not to exceed the regular charges for the service provided.

_____ _____

Patient signature Date

MEDICARE:

I request that payment of medicare benefits be made on my behalf to the physician named above for services rendered to me. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient signature Date

HIPAA Authorization form for family members and family

I,_____, give permission to South Shore Medical Care, P.C. to disclose and release my protected health information described below to:

Name(s): Relationship:

_____ _____

_____ _____

_____ _____

❏ I do not give permission to release my records to any individual

Health information to be disclosed:

❏ My complete health records
❏ Specific health records (as listed below)
❏ _____
_____
_____

This authorization will be effective indefinitely unless i revoke it in writing.

_____ _____
Patients signature Date

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NO SHOW AND CANCELLATION POLICY

Patients are to notify the office within 24 hours of your scheduled appointment time, should you need to cancel or reschedule.

If this notification is not provided or you do not show up to your appointment, a charge of **$25.00** will be billed to your account. ***Please be informed that being late more than 15 minutes is considered a no show and we will have to reschedule.***

Please be advised, if you are scheduled for a physical and do not show up for your appointment, you will be responsible for a **$75.00** charge.

We understand that these are occasional unavoidable situations that may lead to the no show or late cancellation. However, consistent application of this policy is the only way to reinforce the importance of your care. It is our hope that you will come to value the care you receive enough to understand the need for this requirement.

Thank you,

_____
Patients name

_____ _____
Patient/Guardian Signature Date

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Primary Care Provider Change Notice

I was advised by South Shore Medical Care P.C. to update my primary care physician to Dr. Lewandoski by calling my insurance company prior or shortly after my examination. If I choose not to update this information with my insurance carrier, I am aware that I will be fully responsible for any unpaid medical claims.

_____
Patients name

_____ _____
Patient/Guardian Signature Date