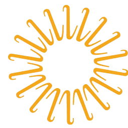


Coastal Medical
Lifespan. Delivering health with care.®

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

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?

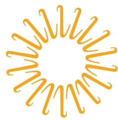
___ Single ___ Partner ___ Married

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



Coastal Medical
Lifespan. Delivering health with care.®

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

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

____

____

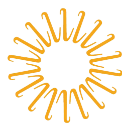
Previous surgery (Place a check mark on the short line next to the type of surgery you have had. On the long line, indicate the approximate date of surgery.):

____ Appendix______________________________
____ Breast surgery__________________________
____ Eye surgery____________________________
____ Gallbladder____________________________
____Hemorrhoids ________________________________
____Hysterectomy _______________________________
____Open heart surgery ___________________________
____Stomach or colon surgery ______________________
____ Other surgery: ____

____

Previous hospitalizations (other than surgery):

Hospital	Year	Reason



Coastal Medical
Lifespan. Delivering health with care.®

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:

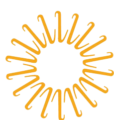
____

____

____

____

____



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

FAMILY HISTORY

Is 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 HABITS

Do 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 ☐ No

If 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

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

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.

____

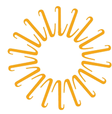
Patient's Signature

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.

Brown University Health - Health Information Management
593 Eddy Street Providence, RI 02903
RI Hospital and Hasbro Children's Tel: 401.444.4040; Fax 401.444.7936
The Miriam Hospital & BHMG Tel: 401.793.2222; Fax:401.793.2247
Newport Hospital Tel: 401.845.1150; Fax: 401.848.6009
Brown Health Medical Group Primary Care Tel: 978.922.0016; Fax: 401.444.6636

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
☐ The Miriam Hospital
☐ Newport Hospital
☐ Brown Health Medical Group, Inc.
☐ Brown Health Medical Group 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.