WENTWORTH HEALTH PARTNERS

Outside Note Other

Patient Identification Area

ADULT HEALTH QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **AGE:** _____ **Sex:** ❑ **M** ❑ **F**

Who was your previous primary care provider? _____

What is your preferred Pharmacy? _____

Preferred language? Written _____ Spoken _____

Are you currently active in a religious community? ❑ Yes ❑ No

Religious Affiliation: _____

Education: What is the highest level of education you have completed?:

❑ Grammar school ❑ High school or equivalent ❑ Some college
❑ Bachelor's degree ❑ Masters degree ❑ Doctoral degree ❑ Other _____

Employment: Are you currently employed? ❑ Yes ❑ No If yes; Employer: _____

Occupation: _____ History of hazardous work conditions (i.e. asbestos etc.) Type: _____

CURRENT MEDICATIONS (may bring own list to visit if you prefer)

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

* Note − this information may be taken directly from the pharmacy label on prescription products

ALLERGIES

❑ No Known Allergies ❑ Medication Allergies ❑ Environmental/Seasonal Allergies ❑ Latex Allergy

List Allergies	Reaction

PAST MEDICAL HISTORY (Check all that apply)

❑ Acid Reflux/GERD
❑ ADHD
❑ Alcoholism
❑ Allergies
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Cancer
❑ Chronic Pain
❑ Depression
❑ Diabetes
❑ Emphysema/Bronchitis/COPD
❑ Epilepsy/Seizure Disorder
❑ Glaucoma/Cataracts
❑ Headaches
❑ Hearing Loss
❑ Heart Disease
❑ High Blood Pressure
❑ High Cholesterol
❑ Irritable Bowel
❑ Kidney Disease
❑ Liver Disease
❑ Osteoporosis
❑ Stroke
❑ Thyroid Disease
❑ Other (please list) − _____

WENTWORTH HEALTH PARTNERS

Patient Identification Area

ADULT HEALTH QUESTIONNAIRE

PAST SURGICAL HISTORY

Date of Surgery (Operations)	Type of Surgery (Operations)

FAMILY HISTORY (Check all that apply)

❑ Asthma ❑ Dementia/Alzheimer's ❑ Depression ❑ Diabetes
❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol ❑ Thyroid Disease
❑ Stroke ❑ Cancer (please specify) _____
❑ Other (please list) − _____

GYN HISTORY

Number of Pregnancies: _____ Number of Living Children: _____

SOCIAL HISTORY

Personal Information

Marital Status ❑ Single ❑ Significant Other ❑ Married ❑ Divorced ❑ Widowed
Name of Significant Other/Spouse if applicable: _____
Children: ❑ Yes ❑ No Number of Sons _____ Number of Daughters _____
Name and Ages of Children: _____
Living Situation: ❑ Live Alone ❑ With Significant Other/Spouse ❑ With Children/Family Members ❑ Other
Occupation: _____
Hobbies/Interests: _____

Tobacco

Have you ever smoked? ❑ Yes ❑ No If yes, what do you (did you) smoke? _____
Are you still smoking? ❑ Yes ❑ No

If no:
How many years ago did you quit? _____
For how many years did you smoke? _____
How many packs/day did you smoke? _____

If yes:
How many years have you smoked? _____
How many packs/day do you smoke? _____
Have you ever tried to quit? _____

Alcohol

Do you drink alcohol including beer, wine, or other alcohol? ❑ Yes ❑ No
If yes please specify frequency:
❑ Daily ❑ Almost Daily (4−6 times/week) ❑ 1−3 times per/week ❑ Less than one time/week

Do you drink caffeine? ❑ Yes ❑ No If yes, how many cups per day? _____

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ❑ Yes ❑ No
(including marijuana, cocaine, amphetamines, pain or anxiety medications, etc)
If yes, please specify type of drug and frequency of use − _____

WENTWORTH HEALTH PARTNERS

Patient Identification Area

ADULT HEALTH QUESTIONNAIRE

Diet/Activity

Are you on any special diet? ❑ Yes ❑ No

If yes, how would you describe your diet? (e.g. South Beach, Atkins, calorie intake, renal, diabetic, low sodium, low fat, etc.)

Do you currently participate in any regular activity to improve or maintain your physical fitness (either on your own or in a formal class)? ❑ Yes ❑ No If yes, please describe: _____

Health Planning

Do you have Advanced Directives in place? ❑ Yes ❑ No

❑ Living Will ❑ Durable Power of Attorney ❑ Health Care Proxy ❑ Advanced Directives

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services, please indicate N/A (not applicable).

All Patients:

Last Tetanus Booster	❑ Within past 10 years	❑ More than 10 years ago		❑ Unknown
Last Eye Examination	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown
Last Hearing Exam	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown
Last sigmoidoscopy / colonoscopy/ Or stool test	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown
Last DEXA Bone Scan	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown
Last Pneumonia Vaccine	Date: _____			
Flu shot this season?	❑ Yes ❑ No			

Women:

Last Pap Smear	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown
Last Mammogram	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown

Men:

Last Prostate Specific Antigen−PSA	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown
Last Prostate Exam	Date: _____	❑ Normal	❑ Abnormal	❑ Unknown

CONCERNS

Please indicate any concerns regarding your health in the space provided.

Patient Name (printed): _____

Patient Signature: _____ **Date:** _____

We would like to personally thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

PRINT SAVE AS RESET

PARTNERS HEALTHCARE

WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

Mail or Fax To:
Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143−4453
Phone: 617−726−2361
Fax: 844−918-0781

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

A. PATIENT INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

PATIENT MEDICAL RECORD #: _____

PATIENT ADDRESS: STREET: _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE CONTACT #: DAY: ( ) _____ **EVENING: ( )** _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

FROM: (e.g. hospital, clinic, or provider name):

Name: _____

Address: _____

_____

Telephone Number: _____

PURPOSE: (check the appropriate box):

- ❑ Medical Care
- ❑ Insurance*
- ❑ Legal Matter*
- ❑ Personal*
- ❑ School
- ❑ Other (please specify)* _____

* Copying fees may apply

TO: (e.g. to whom you would like the information sent):

❑ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:

Name: _____

Address: _____

_____

Telephone Number: _____

SEND BY:

- ❑ Partners Patient Gateway (if available)
- ❑ Secure Email (provide email address below)
  Patient Email Address: _____
- ❑ Paper Copy via Mail
- ❑ Fax (provide fax number): _____

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

- ❑ Medical Record Abstract/dates: _____
  (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ❑ Clinic Visit Notes/dates: _____
- ❑ Discharge Summary/dates: _____
- ❑ Lab Reports/dates: _____
- ❑ Operative Reports/dates: _____
- ❑ Pathology Reports/dates: _____
- ❑ Radiation Reports/dates: _____
- ❑ Radiology Reports/dates: _____
- ❑ Photographs/dates (costs may apply): _____
- ❑ Billing Records/dates: _____
- ❑ Other *(please specify below and include dates):* _____

_____

_____

_____

_____

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PARTNERS HEALTHCARE

WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

D. Please check YES to indicate if you give permission to release the following information if present in your record:

❑ Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES:_____

❑ Yes **Genetic Screening test results (SPECIFY TYPE OF TEST):** _____

❑ Yes **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

❑ Yes **Other(s):** Please List: _____

❑ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)

❑ Yes Confidential Communications with a Licensed Social Worker

❑ Yes Details of Domestic Violence Victims' Counseling

❑ Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - ❍ if PHS has already relied upon it (for example, once information is released, it will not be retrieved)
  - ❍ if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- I understand that if Partners maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

➢ **Signature of Legal Representative:** _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____

Clinic/Office: _____

Pick−up Identification:

❑ License ❑ State ID ❑ Passport ❑ Other Photo ID _____

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