RALEIGH INFECTIOUS DISEASES ASSOCIATES, P.A.
MEDICAL QUESTIONAIRE

NAME____ **DATE OF BIRTH** _______________
Last First Middle Mo Day Yr.

Referred by: _________________Reason for visit:____

PAST MEDICAL HISTORY: Conditions for which you have seen a Doctor, including psychiatric. Circle those that apply, or list conditions for which you are being treated.

Diabetes High Blood Pressure Heart Attack Stroke Gout TB Hepatitis
Cancer Jaundice Urinary Tract Infections Kidney Stones Depression
Seizures Pneumonia Asthma HIV Infection Thyroid Conditions
High Cholesterol

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Hospitalization(s) Including Psychiatric

______________________________Year________ ______________________________Year________

______________________________Year________ ______________________________Year________

______________________________Year________ ______________________________Year________

Please list all prescription or over the counter medications, herbs, supplements, or vitamins you are now taking:

______________________________ ______________________ ______________________

______________________________ ______________________ ______________________

Pharmacy: ___________________________Phone #____

List any drug allergies or reactions you have had:
Drug ____________________ Reaction____
Drug ____________________ Reaction____

FOR WOMEN ONLY:
Date of last menstrual period: __________ Are you using birth control? Y N Type: ____________
Number of Pregnancies __________ Number of Births _______________

SOCIAL HISTORY:
Birth Place: _____________________
Current Residence: ________________________
Highest Level of Education: ________________
Occupation: _____________________________
Military Service: Y N Stationed overseas? Y N
Where were you stationed? _________________
Marital Status_______________Children________________Type of Residence________________
Patient lives with______________________________________
Tobacco: Uses tobacco Y N Formerly Type__________________Year Quit________________
Alcohol: Drinks alcohol Y N Formerly Type__________________Year Quit________________
Uses street drugs?______________________Type________________________
What are your hobbies?____
Patient eats Sushi___________Raw shellfish_________________
Pets in the home Y N Type of pet____________________Do you clean up after your pet?____________
Religious Affiliation? ____
Does your home have well water _____ or city water ______?
Recent travel?____
What Countries have you visited? ____

NAME____ **DATE OF BIRTH**_______________

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Have you ever:

received a blood transfusion?	Y N	Year ________
donated blood?	Y N	Year ________
had hepatitis?	Y N	
been exposed to tuberculosis / TB?	Y N	
Agree to blood transfusion if needed?	Y N	

How many sexual partners have you had during your lifetime? ________
Do you think of yourself as heterosexual (straight), homosexual (gay), or bisexual (bi)? ________
Have you ever had a homosexual contact? Y N
Have you had a sexually transmitted disease? Y N
(VD, GCS, gonorrhea, syphilis, herpes, genital warts)?

When was the last time (Year) you had:

Flu vaccine	__________	Dental exam	__________
Pneumococcal vaccine	__________	Eye exam	__________
Hepatitis B vaccine	__________	Colonoscopy	__________
Hepatitis A vaccine	__________	Pap smear	__________
Tetanus vaccine	__________	Mammogram	__________

HIV test __________ Result __________
Tuberculosis /TB test __________ Result __________

Family History (Cancer, heart disease, Diabetes, TB etc.)
Mother ____
Father ____
Siblings ____
Children ____

SYSTEM REVIEW: Please CIRCLE any problems that you are NOW experiencing.
CONSTITUTIONAL: fever, sweats, appetite/weight change, fatigue, weakness, changes in sleep
SKIN: itching, rash, warts, hair changes, nonhealing skin problems
EYES: blurred vision, double vision, glaucoma
EARS, NOSE, THROAT: ringing in your ears, hearing loss, vertigo, sinus infection, seasonal allergies, recurrent Strep throat, bloody nose, runny nose
CARDIOVASCULAR: chest pain, fainting, heart murmur, high blood pressure, leg swelling, phlebitis, shortness of breath, irregular heart rhythm, rheumatic fever
RESPIRATORY: cough, cough up blood, bronchitis, pneumonia, wheezing, asthma
GASTROINTESTINAL: constipation, diarrhea, indigestion, abdominal pain, nausea, vomiting,swallowing difficulty, diverticulitis, polyps, hemorrhoids, ulcers, liver disease, gall bladder disease, pancreatitis, reflux, heartburn
GENITOURINARY: burning, dribbling, frequency, hesitancy, incontinence, urgency, blood in urine, recurrent infection, kidney stones
MUSCULOSKELETAL: arthritis, joint swelling, muscular pain, muscle weakness
NEUROLOGICAL: dizziness, fainting, headaches, bowel or bladder incontinence, memory impairment, numbness, seizures, speech difficulties, tremor, weakness
PSYCHIATRIC: anxious, depressed, sleeping difficulties, history of counseling
HEMATOLOGIC/LYMPHATIC: anemia, sickle cell disease, swollen lymph nodes, easy bruising or bleeding
ALLERGIC/IMMUNOLOGIC: allergies, asthma, rash
ENDOCRINE: diabetes, thyroid disease

Completed by:______________________________ Date:____________________

Reviewed by: ______________________________ Date:____________________

Raleigh Infectious Diseases Associates

2304 Wesvill Court
Raleigh, NC 27607-2973
(919) 571-1567

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I hereby release my insurance benefits to be paid directly to the physicians at Raleigh Infectious Diseases Associates . I hereby authorize the release of pertinent medical information to my insurance carriers and to healthcare providers deemed necessary to participate in my care.
I understand and agree that, regardless of my insurance status, I am ultimately financially responsible for the balance of my account for any professional services rendered.

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________

Raleigh Infectious Diseases Associates, PA
Acknowledgement of Notice of Privacy Practices

Name ______________________________ DOB ____________________

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of this notice may change. If we change our notice, you may obtain a revised copy by requesting one at your next appointment or contacting our Privacy Officer. You have the right to request restrictions as to how PHI about you is used or disclosed for treatment, payment and health care operations. Any special requests will be reviewed and addressed. We are not required to agree to this restriction. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.
By signing this form, you consent to our use and disclosure of protected health information for the purposes of treatment, payment and health care operations. Sharing of PHI may include release of information to other physicians, institution or healthcare agency as necessary to provide treatment or diagnosis. This may include sensitive information such as HIV status and mental health information. We will also share information in order to process insurance or worker's comp claims and to facilitate payment for services.

Acknowledgement of Ways in Which You May Be Contacted

In order to contact you regarding treatment, payment and health care operations, we would like for you to be aware of ways in which you may be contacted. You may be contacted through the work, home, and mobile phone numbers. Our staff may leave discreet messages on your answering machine, voice mail, or with others. Appointment reminders, account statements, and medical correspondence will be mailed to your home address, as well as other information that is critical to our treatment, payment and healthcare operation. We may not release information to family members, spouses, legal representatives without specific written consent as indicated below.

Please list all phone numbers and indicate your 1ST and 2nd preference by checking the corresponding box.

☐ **Home phone**____________________

☐ **Work phone** ____________________

☐ **Cell phone** ____________________

Please list one family member or other representative with whom we may discuss your healthcare and/or billing information:

Name: ______________________________**Relationship:**_______________

Phone : ______________________________

Other specific request:____

____

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______________________________ ______________________________

Signature **Date**

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