PATIENT QUESTIONNAIRE

PATIENT'S NAME _____ BIRTH DATE _____ SEX _____ S.M.W

ADDRESS _____ TEL. NO. _____

INSURANCE _____ REFERRED BY _____ OCCUPATION _____

INSTRUCTIONS: PUT ☑ IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

FAMILY HISTORY

	FATHER	MOTHER	BROTHER 1	BROTHER 2	BROTHER 3	BROTHER 4	SISTER 1	SISTER 2	SISTER 3	SISTER 4	SPOUSE	CHILDREN 1	CHILDREN 2	CHILDREN 3	CHILDREN 4	CHILDREN 5	CHILDREN 6
AGE (IF LIVING)																	
HEALTH (G) GOOD (B) BAD																	
CANCER																	
TUBERCULOSIS																	
DIABETES																	
HEART TROUBLE																	
HIGH BLOOD PRESSURE																	
STROKE																	
EPILEPSY																	
NERVOUS BREAKDOWN																	
ASTHMA, HIVES, HAY FEVER																	
BLOOD DISEASE																	
AGE (AT DEATH)																	
CAUSE OF DEATH																	

PERSONAL HISTORY

HAVE YOU EVER HAD	NO	YES	HAVE YOU EVER HAD	NO	YES	HAVE YOU EVER HAD	NO	YES
☐ SCARLET FEVER ☐ SCARLATINA			☐ GONORRHEA ☐ SYPHILIS			ANY ☐ BROKEN ☐ CRACKED BONES		
DIPHTHERIA			ANEMIA			RECURRENT DISLOCATIONS		
SMALLPOX			JAUNDICE			☐ CONCUSSION ☐ HEAD INJURY		
PNEUMONIA			EPILEPSY			EVER BEEN KNOCKED UNCONSCIOUS		
PLEURISY			MIGRAINE HEADACHES			☐ FOOD ☐ CHEMICAL ☐ DRUG POISONING		
UNDULANT FEVER			TUBERCULOSIS			EXPLAIN		
☐ RHEUMATIC FEVER ☐ HEART DISEASE			DIABETES					
ST. VITUS DANCE			CANCER					
☐ ARTHRITIS ☐ RHEUMATISM			☐ HIGH ☐ LOW BLOOD PRESSURE			ANY OTHER DISEASE		
ANY ☐ BONE ☐ JOINT DISEASE			NERVOUS BREAKDOWN			EXPLAIN		
☐ NEURITIS ☐ NEURALGIA			☐ HAY FEVER ☐ ASTHMA					
☐ BURSITIS ☐ SCIATICA ☐ LUMBAGO			☐ HIVES ☐ ECZEMA					
☐ POLIO ☐ MENINGITIS			FREQUENT ☐ COLDS ☐ SORE THROAT			WEIGHT: NOW ONE YR. AGO		
BRIGHT'S DISEASE			FREQUENT ☐ INFECTIONS ☐ BOILS			MAXIMUM WHEN		

ALLERGIES

ARE YOU ALLERGIC TO	NO	YES	ARE YOU ALLERGIC TO	NO	YES	ARE YOU ALLERGIC TO	NO	YES
☐ PENICILLIN ☐ SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
☐ ASPIRIN ☐ CODEINE ☐ MORPHINE			EXPLAIN			EXPLAIN		
☐ MYCINS ☐ OTHER ANTIBIOTICS								
☐ TETANUS ☐ ANTITOXIN ☐ SERUMS			ADHESIVE TAPE			☐ NAIL POLISH ☐ OTHER COSMETICS		

SURGERY

HAVE YOU HAD REMOVED	NO	YES	HAVE YOU HAD REMOVED	NO	YES	HAVE YOU	NO	YES
TONSILS			☐ OVARY ☐ OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			HAD ANY OTHER OPERATIONS		
GALL BLADDER			EVER HAVE A TRANSFUSION			BEEN HOSPITALIZED FOR ANY ILLNESS		
UTERUS			☐ BLOOD ☐ PLASMA			EXPLAIN		

X-RAYS

EVER HAVE X-RAYS OF	NO	YES	DATE	DISEASE PRESENT
CHEST				
☐ STOMACH ☐ COLON				
GALL BLADDER				
EXTREMITIES				
BACK				
OTHER				

SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD . . .	NO	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD . . .	NO	YES
ANY ☐ EYE DISEASE ☐ EYE INJURY ☐ IMPAIRED SIGHT			KIDNEY ☐ DISEASE ☐ STONES		
ANY ☐ EAR DISEASE ☐ EAR INJURY ☐ IMPAIRED HEARING			BLADDER DISEASE		
ANY TROUBLE WITH ☐ NOSE ☐ SINUSES ☐ MOUTH ☐ THROAT			BLOOD IN URINE		
FAINTING SPELLS			☐ ALBUMIN ☐ SUGAR ☐ PUS ☐ ETC. IN URINE		
CONVULSIONS			DIFFICULTY IN URINATION		
PARALYSIS			NARROWED URINARY STREAM		
DIZZINESS			ABNORMAL THIRST		
HEADACHES: ☐ FREQUENT ☐ SEVERE			PROSTATE TROUBLE		
ENLARGED GLANDS			☐ STOMACH TROUBLE ☐ ULCER		
THYROID: ☐ OVERACTIVE ☐ UNDERACTIVE ☐ ENLARGED			INDIGESTION		
ENLARGED GOITER			☐ GAS ☐ BELCHING		
SKIN DISEASE			APPENDICITIS		
COUGH: ☐ FREQUENT ☐ CHRONIC			☐ LIVER DISEASE ☐ GALL BLADDER DISEASE		
☐ CHEST PAIN ☐ ANGINA PECTORIS			☐ COLITIS ☐ OTHER BOWEL DISEASE		
SPITTING UP BLOOD			☐ HEMORRHOIDS ☐ RECTAL BLEEDING		
NIGHT SWEATS			BLACK TARRY STOOLS		
SHORTNESS OF BREATH ☐ EXERTION ☐ AT NIGHT			☐ CONSTIPATION ☐ DIARRHEA		
☐ PALPITATION ☐ FLUTTERING HEART			☐ PARASITES ☐ WORMS		
SWELLING OF ☐ HANDS ☐ FEET ☐ ANKLES			☐ ANY CHANGE IN APPETITE ☐ EATING HABITS		
VARICOSE VEINS			☐ ANY CHANGE IN BOWEL ACTION ☐ STOOLS		
EXTREME ☐ TIREDNESS ☐ WEAKNESS			EXPLAIN		

IMMUNIZATION - EKG

HAVE YOU HAD . . .	NO	YES	HAVE YOU HAD . . .	NO	YES
SMALLPOX VACCINATION (WITHIN LAST 7 YEARS)			POLIO SHOTS (WITHIN LAST 2 YEARS)		
TETANUS SHOT (NOT ANTITOXIN)			AN ELECTROCARDIOGRAM WHEN		

HABITS

DO YOU . . .	NO	YES	DO YOU USE . . .	NEVER	OCC	FREQ	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			SEDATIVES				
SLEEP WELL			TRANQUILIZERS				
AVERAGE 8 HOURS SLEEP (PER NIGHT)			SLEEPING PILLS, ETC.				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRINS, ETC.				
SEX - ENTIRELY SATISFACTORY			CORTISONE				
LIKE YOUR WORK (HOURS PER DAY) ☐ INDOORS ☐ OUTDOORS			ALCOHOLIC BEVERAGES				
WATCH TELEVISION (HOURS PER DAY)			COFFEE (CUPS PER DAY)				
READ (HOURS PER DAY)			TOBACCO: ☐ CIGARETTES (PKS PER DAY)				
HAVE A VACATION (WEEKS PER YEAR)			☐ CIGARS ☐ PIPE ☐ CHEWING TOBACCO				
HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM			☐ SNUFF				
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			APPETITE DEPRESSANTS				
RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK.			THYROID MEDICATION: ☐ NO ☐ YES, IN PAST ☐ NONE NOW NOW ON GR. DAILY				
			HAVE YOU EVER TAKEN . . .				
			☐ INSULIN ☐ TABLETS FOR DIABETES ☐ HORMONE SHOTS ☐ TABLETS ☐ NO				

WOMEN ONLY

MENSTRUAL HISTORY				NO	YES
AGE AT ONSET			ARE YOU REGULAR: ☐ HEAVY ☐ MEDIUM ☐ LIGHT		
USUAL DURATION OF PERIOD	DAYS		DO YOU HAVE ☐ TENSION ☐ DEPRESSION BEFORE PERIOD		
CYCLE (START TO START)	DAYS		DO YOU HAVE ☐ CRAMPS ☐ PAIN WITH PERIOD		
DATE OF LAST PERIOD			DO YOU HAVE HOT FLASHES		
PREGNANCIES . . .	NO	YES		NO	YES
CHILDREN BORN ALIVE (HOW MANY)			STILL BORN (HOW MANY)		
CESAREAN SECTIONS (HOW MANY)			MISCARRIAGES (HOW MANY)		
PREMATURES (HOW MANY)			ANY COMPLICATIONS		

EMOTIONS

ARE YOU OFTEN . . .	NO	YES	ARE YOU OFTEN . . .	NO	YES
DEPRESSED			JUMPY		
ANXIOUS			JITTERY		
IRRITABLE			IS CONCENTRATION DIFFICULT?		

Nephrology – Hypertension of Naples, P.L.

PATIENT INFORMATION SHEET *DATE:*_____

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **PATIENT ID #** (to be filled out by office staff)

__/__/__ **DATE OF BIRTH** **SOCIAL SECURITY NUMBER** **AGE** **SEX** **MARITAL STATUS**

ADDRESS **STREET** **APT. #** **CITY** **STATE** **ZIP**

(_____)_____ (_____)_____ **HOME PHONE** **CELL** **REFERRING PHYSICIAN** **PRIMARY CARE PHYSICIAN**

SECONDARY ADDRESS: STREET **CITY** **STATE** **ZIP**

DO YOU LIVE HERE: FULL TIME OR PART TIME. If Part time, how may months? _____

_____(_____) _____
EMERGENCY CONTACT **RELATIONSHIP** **EMERGENCY**

_____(_____) _____
NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU RELATIONSHIP TO PATIENT PHONE

PHARMACY MOST COMMONLY USED **PHONE**

PRESCRIPTION DRUG COVERAGE PLAN:_____

MEDICAL INSURANCE INFORMATION – Please show the receptionist your card.

PRIMARY CARRIER

SUBSCRIBER NAME DATE OF BIRTH

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT

INSURANCE COMPANY POLICY # GROUP #

COMPANY ADDRESS PHONE NUMBER

SECONDARY CARRIER

SUBSCRIBER NAME DATE OF BIRTH

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT

INSURANCE COMPANY POLICY # GROUP #

COMPANY ADDRESS PHONE NUMBER

FINANCIAL AGREEMENT:

I / We _____ (Patient) and _____ (Guarantor) agree to be financially responsible for the cost of all medical services rendered to the Patient by *Nephrology-Hypertension of Naples, P.L.* The cost of these services shall be in accordance with the fee schedule in effect at the time of service. The undersigned agree(s) to pay, in addition to the doctor's fees, any and all costs of collecting the amount due on that date. I / We acknowledge receipt of a copy of this agreement and fully agree to and understand the condition set forth regardless of any insurance coverage, court litigation, or other party involvement.

NOTE: Nephrology-Hypertension of Naples, PL will bill your primary insurance. If the information given to the office is no longer valid, or has been provided to us incorrectly, you will be responsible for all charges incurred at the time of service. You will also be responsible for any non-covered service by your insurance company. You agree to cover these charges regardless of any insurance coverage, court litigation, or other party involvement.

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) DATE

WITNESS DATE

To All **Nephrology Hypertension of Naples PL Patients**

Starting January 1, 2011 our office will incorporate a new policy.

BLOOD WORK OR RADIOLOGY RESULTS OR REPORTS WILL NOT BE GIVEN OVER THE TELEPHONE TO ANY PATIENT.

Your laboratory and/or radiology results and reports
will be discussed with you in person
on the date you have scheduled your follow up office visit, unless Dr. Sterrett discusses otherwise.

Your reports will not be available before that time, *unless* there is an urgent reason and immediate action is required, or Dr. Sterrett has made other arrangements. In that event **the office will contact *you*.**

If you would like a copy of your results on the day of your visit, feel free to ask one of our associates or the doctor, and we will be happy to provide you with them. Thank-you for your understanding.

Please sign in acknowledgement below:

X_____ Date: _____

Nephrology-Hypertension of Naples, PL
6101 Pine Ridge Road Desk 32
Naples, FL 34119
(239) 348-8804
(239) 348-8836 (fax)

RELEASE OF HEALTH RELATED INFORMATION

Patient Name:_____
Patient ID #:_____

I authorize Nephrology-Hypertension of Naples, PL to release information about my health condition to the following family members/ friends:

Name	Relationship

I authorize Nephrology-Hypertension of Naples, PL to leave messages on my answering machine/ voice mail regarding health information and/or reminder calls for my appointments.

☐ YES ☐ NO

Please sign below:

_____ _____
Name Date Witness Date

_____
Legal Representative/Guardian Date

Nephrology-Hypertension of Naples, PL
6101 Pine Ridge Road Desk 32
Naples, FL 34119
Phone: (239) 348-8804
Fax: (239) 348-8836

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Date:_____

I Authorize _____

_____

_____

_____

To release information from the medical record of:

Name:_____

DOB:_____

SSN:_____

TO: **Nephrology-Hypertension of Naples, PL**
6101 Pine Ridge Rd, Desk 32
Naples, FL 34119
Phone: 239-348-8804
Fax: 239-348-8836

Information to be released:

_____ Complete medical file excluding psychiatric, substance abuse, HIV/AIDS related information.

_____ Complete medical file including psychiatric, substance abuse, HIV/AIDS related information.

_____ Other:_____

Patients Signature: _____ Date: _____

Patients Legal Representative: _____ Relationship to Patient: _____

Witness: _____

It is my intent that information furnished is prohibited for any purpose other than for the purpose state above. I understand I may revoke this consent at any time before the information has been released. A copy of this authorization will be accepted as the original. I authorize the listed parties to release or obtain records from/ to the parties listed above, and thus release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records. This request will expire within 180 days of its signed date.

Nephrology-Hypertension of Naples, PL
6101 Pine Ridge Road Desk 32
Naples, FL 34119
Phone: (239) 348-8804
Fax: (239) 348-8836

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Date:_____

I Authorize **Nephrology-Hypertension of Naples, PL**
6101 Pine Ridge Rd, Desk 32
Naples, FL 34119
Phone: 239-348-8804
Fax: 239-348-8836

To release information from the medical record of:

Name:_____

DOB:_____

SSN:_____

Reason:

- ☐ Seasonal / Seeing another physician
- ☐ Permanently leaving Practice
- ☐ Referral
- ☐ Other: _____

TO: _____

Phone: _____ **Fax:** _____

Patient's Signature: _____ Date: _____

Patient's Legal Representative: _____ Relationship to Patient: _____

Witness: _____

Please allow 48-72 hours for request to be completed. If you have any questions or need this to be completed immediately, please contact the office.

It is my intent that information furnished is prohibited for any purpose other than for the purpose stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand I may revoke this consent at any time before the information has been released. A copy of this authorization will be accepted as the original. I authorize the listed parties to release or obtain records from/ to the parties listed above, and thus release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance to this authorization. I further direct that a photocopy of this authorization be granted the same authority as the original. This request will expire within 180 days of its signed date.

Nephrology-Hypertension of Naples, PL
6101 Pine Ridge Road Desk 32
Naples, FL 34119
Phone: (239) 348-8804
Fax: (239) 348-8836

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Date:_____

I Authorize:

HMA, Physicians Regional Medical Center Pine Ridge,

Physicians Regional Medical Center Collier Blvd,

Physicians Regional Medical Group, James Reid Sterrett, MD

To release information from the medical record of:

Name:_____

DOB:_____

SSN:_____

TO: **Nephrology-Hypertension of Naples, PL**
6101 Pine Ridge Rd, Desk 32
Naples, FL 34119
Phone: 239-348-8804
Fax: 239-348-8836

Information to be released:

_____ Complete medical file excluding psychiatric, substance abuse, HIV/AIDS related information.

_____ Complete medical file including psychiatric, substance abuse, HIV/AIDS related information.

_____ Other:_____

Patients Signature: _____ Date: _____

Patients Legal Representative: _____ Relationship to Patient: _____

Witness: _____

It is my intent that information furnished is prohibited for any purpose other than for the purpose stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand I may revoke this consent at any time before the information has been released. A copy of this authorization will be accepted as the original. I authorize the listed parties to release or obtain records from/ to the parties listed above, and thus release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance to this authorization. I further direct that a photocopy of this authorization be granted the same authority as the original. This request will expire within 180 days of its signed date.