PATIENT HISTORY QUESTIONNAIRE

TODAY'S DATE _____

This form will be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **THANK YOU!**

NAME _____ **DOB** _____

PRIMARY PHYSICIAN _____ **REFERRING PHYSICIAN** _____

REASON FOR TODAY'S VISIT _____

_____ Approximate date of onset _____

IS VISIT RELATED TO WORK OR AUTO INJURY? YES NO Date of Injury _____

ARE YOU SENSITIVE TO: LATEX YES NO **ADHESIVES** YES NO **IODINE/SEAFOOD** YES NO

ARE YOU ALLERGIC TO ANY MEDICINES? YES NO Please list along with the reaction(s)_____

_____

PLEASE LIST <u>ALL CURRENT MEDICATIONS</u> (including <u>aspirin products</u> or <u>blood thinners</u>) **AND the DOSAGE & FREQUENCY:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you recently been on any steroids? YES NO How much & when? _____

SOCIAL HISTORY:

Do you smoke? YES NO How much & how long? _____

Do you drink alcohol? YES NO How much & how often? _____

Do you use recreational drugs? YES NO Kind & how often? _____

FAMILY HISTORY:

Breast Cancer YES NO Who _____ Diabetes YES NO Who _____

Colon Cancer YES NO Who _____ Heart Disease YES NO Who _____

Melanoma YES NO Who _____ Hypertension YES NO Who _____

Other Cancers YES NO Who _____ Other _____

PLEASE LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

Operation or illness	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems with anesthesia? YES NO Describe _____

Recent x-rays, labs or tests related to the present illness

_____ _____ _____

_____ _____ _____

PLEASE INDICATE WITH A CIRCLE THOSE MEDICAL CONDITIONS THAT YOU HAVE:

Asthma
Emphysema/COPD
Sleep apnea
High blood pressure
Heart arrhythmia
Heart murmur
Kidney disease
Diabetes
Thyroid disease
Seizures
Stroke
Lupus
Hepatitis
Crohn's Disease
Ulcerative Colitis
Irritable Bowel
Cancer: _____
_____
Other: _____
_____

PATIENT NAME _____ **DOB** _____

Please circle "yes" or "no" for each item on the list below:

CONSTITUTIONAL

No Yes Good general health lately
No Yes Recent significant weight loss
No Yes Recent significant weight gain
No Yes Fevers/night sweats
No Yes Fatigue/weakness
No Yes Headaches

EYES

No Yes Change in vision
No Yes Eye disease or injury

EARS/NOSE/THROAT/MOUTH

No Yes Difficulty hearing
No Yes Ringing in ears
No Yes Problems with teeth or gums
No Yes Hoarseness
No Yes Pain with swallowing

CARDIOVASCULAR

No Yes Chest pain or angina
No Yes Palpitation
No Yes Shortness of breath when lying flat
No Yes Swelling of feet, ankles

RESPIRATORY

No Yes Cough
No Yes Wheeze
No Yes Difficulty breathing

GASTROINTESTINAL

No Yes Difficulty swallowing
No Yes Loss of appetite
No Yes Change in bowel movements
No Yes Nausea or vomiting
No Yes Frequent diarrhea
No Yes Constipation
No Yes Liver disease
No Yes Rectal bleeding or blood in stools
No Yes Abdominal pain
No Yes Ulcer (stomach)

GENITOURINARY

No Yes Blood in the urine
No Yes Difficulty urinating

MUSCULOSKELETAL

No Yes Muscle pain
No Yes Joint pain

SKIN/BREAST

No Yes Mole change
No Yes Rash
No Yes Itching
No Yes Change in nails
No Yes Breast lump
No Yes Breast pain
No Yes Nipple discharge

NEUROLOGICAL

No Yes Dizziness/lightheadedness
No Yes Numbness
No Yes Seizures
No Yes Loss of coordination

PSYCHIATRIC

No Yes Memory loss or confusion
No Yes Problems with sleep

ENDOCRINE

No Yes Glandular or hormone problem
No Yes Goiter
No Yes Excessive thirst or urination

BLOOD/LYMPHATIC

No Yes Bleeding or bruising tendency
No Yes Anemia
No Yes Blood clots or pulmonary emboli
No Yes Sickle cell anemia or trait
No Yes History of blood transfusion
No Yes Enlarged glands

ALLERGIC/IMMUNOLOGIC

No Yes HIV or AIDS
No Yes Tuberculosis

GYNECOLOGICAL

No Yes Abnormal vaginal discharge
No Yes Abnormal uterine bleeding
No Yes Oral Contraceptive use
No Yes Hormone replacement therapy
Age of first menses: _____
Age of menopause: _____
No. of pregnancies: _____
Age at first pregnancy: _____

Physician reviewer: _____ Date: _____

SURGICAL SPECIALISTS Hilton Head General & Laparoscopic Surgery, PA (HHGLS)
Thomas P. Rzeczycki, MD, FACS Richard L. Hussong, Jr., MD, FACS
25 Hospital Center Commons, Suite 100 Hilton Head Island, SC 29926 (843) 681-9489

PATIENT ENROLLMENT

Last Name ___________________________________ First Name ___________________________ MI _____________

Mailing Address ____

City ____ State ___________________ Zip Code _________________

Home Phone _________________________ Work Phone _________________________ Cell _______________________

Date of Birth _____________________ SSN _________________________ email______________________________

Sex (circle one) M F Marital Status (circle one) Single Married Divorced Separated Other

Employer ____

Insurance Policy Holder Social Security # (necessary to file with your insurance) ________________________________

Our office appointment schedule can change at a moment's notice due to emergencies. Please circle the phone number that is your preferred contact: Home Work Cell

I give permission to HHGLS to convey information regarding my appointments and/or medical issues via:

voicemail/answering machine: Yes No email: Yes No

If desired, please designate a family member/friend who may access your medical records and discuss your medical conditions: Name _______________________________ relationship __________________ phone __________________

Signed ____ Date ____

**************PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE STAFF FOR COPYING**************

FINANCIAL AGREEMENT

Payment is expected at the time of service. Cash, check or major credit card is accepted in the form of payment. Third party payments of assignment are generally accepted for services. All deductibles, co-pays, and co-insurances are due at the time of service. I hereby authorize the payment of any insurance or other medical benefits to Hilton Head General & Laparoscopic Surgery, PA (HHGLS).

I understand that my insurance, if any, is a contract between myself and my insurance company, except in certain cases where Drs. Rzeczycki, and Hussong have signed a contract with my PPO or other third party**. I understand that any balance due after my insurance has been processed will be my responsibility,** and shall be paid within 30 days of the first billing, unless other arrangements are made.

I hereby authorize the payment of any insurance or other medical benefits to HHGLS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the HHGLS NOTICE OF PRIVACY POLICIES, detailing how my information maybe used and disclosed as permitted under federal and state law. I understand the content of the Notice and I request the following restriction concerning the use of my medical records: ____

____

____

Further, I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to the medical assignment of benefits applies.

Signed ____ Date ____

If not signed by the patient, please indicate relationship to patient.

Relationship _______________________________________ Witnessed ____

****

OFFICE USE ONLY

If the patient or patient representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented and sign below:

Presented on (date & time) ____________________ By (name of staff member) _________

Hilton Head General & Laparoscopic Surgery, P.A.

dba "Surgical Specialists"

NOTICE OF PRIVACY PRACTICES

Effective Date: 4/1/2003; Revised 9/16/2012, 1/6/2016, 11/2/2017

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Surgical Specialists, we are committed to protecting your personal health information. Each time you are seen by one of our physicians in our office, a record is made containing your symptoms, history, physical examination, test results, treatment, plan for future care, and billing-related information. This notice applies to all information in your medical record generated, received or transmitted by our medical practice. While your medical record is the physical property of Surgical Specialists, the information contained therein belongs to you.

Our Responsibilities and Your Rights

We are required by Federal and/or South Carolina state law to maintain the privacy of your protected health information; to provide you with this notice of our privacy practices and a paper copy upon request; to abide by the terms of our current notice; to accommodate reasonable written requests by you to amend health information you believe to be incorrect or incomplete; to accommodate reasonable written requests by you to restrict or limit health information communicated to other individuals or entities involved in your medical care; to accommodate reasonable written requests by you restricting how our practice communicates with you; to provide upon your written request an accounting of certain disclosures of your health information made for purposes other than treatment, payment or health care operations where an authorization was not required; to submit a written revocation of a previous authorization to release your protected health information; to permit you to inspect and copy your protected health information, with the exception of psychotherapy notes.

How We May Use and Disclose Your Protected Health Information Without Your Written Authorization

- For Treatment
- For Payment
- For Health Care Operations
- For Appointment Reminders
- For Treatment Alternatives and Services
- For Business Associate Functions
- For Abuse, Neglect or Domestic Violence Reporting
- For Public Health Reporting
- For Law Enforcement/Legal Proceedings, as required by law or in response to a valid subpoena
- For Correctional Institutions, for inmates
- For Military Command Authorities
- For Food and Drug Administration
- For Organ and Tissue Donation Organizations
- For Funeral Directors, Coroners and Medical Examiners
- For Workers Compensation Agents
- For Health Oversight Agencies
- For National Security and Intelligence Agencies
- For Protective Services for the President and Others

Complaint Process

If you believe that your privacy rights have been violated by us, you may file a complaint without fear of retaliation by contacting the Regional Manager of the Office for Civil Rights:

Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Telephone (404)562-7453
FAX (404)562-7881