ADVANCED INTEGRATIVE MEDICINE

TERESE TAYLOR M.D.

Date: _____ Social Security # _____

PATIENT NAME: _____Date of Birth: _____/_____/_____
Last First M.I.

Home address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ E-Mail : _____

Employer: _____ Occupation: _____

Employer Phone: _____ Pharmacy Name & #: _____

SPOUSE OR SIGNIFICANT OTHER:

Name: _____ Home Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

_____

Relationship: _____ Phone: _____

Referred to our office by: _____

Phone: 239.540.9918 | **Fax:** 239-540-9921 | **Address:** 4202 Del Prado Blvd. S., Cape Coral FL, 33904
www.DrTereseTaylor.com

COMPLETE MEDICAL HISTORY FORM DATE: _____

NAME: _____ **AGE**: _____ **DATE OF BIRTH:** _____

1. PAST MEDICAL HISTORY

A. Surgeries:

T & A (tonsils) Date: _____ Hysterectomy Date: _____
Appendectomy Date: _____ Ovaries Removed? (circle one) YES / NO
Gallbladder Date: _____ Was Hysterectomy done to remove cancer? YES / NO
Other surgeries and dates: _____
Biopsies Done: What kind and dates: _____

B. Hospitalization: (other than for surgeries)

Date: Where: Reasons:
_____
_____
_____

C. Injuries / Fractures (type, date and how injured):

_____
_____

D. Present Medications (prescription and over the counter):

_____
_____
_____

Herbs and Supplements:

_____

E. Allergies: Are you allergic to any:

Medications: What Reaction?:
_____
_____

Other Substances, Food, Etc:

_____
_____

F. Immunizations: Check Childhood Shots Given:

DPT: _____ Mumps: _____ Rubella: _____ Polio: _____ Smallpox: _____
Tetanus Booster Date: _____
Pneumovax (pneumonia vaccine): Date: _____
Influenza (date of last shot): Date: _____
Hepatitis B (series of 3 shots): Date: _____
Other shots: _____

2. FAMILY HISTORY

Father: Age (if living): _____ Age (at death): _____ Cause of Death: _____
List any medical problems that he has had:
_____
_____

Mother: Age (if living): _____ Age (at death): _____ Cause of Death: _____
List any medical problems that she has had:
_____
_____

Brother(s): Ages and any medical problems he/they have had:
_____
_____

Sister(s): Ages and any medical problems she/they have had:
_____
_____

Children: Ages/Sex and any medical problems they have had:
_____
_____

Any other blood relatives with a history of:

	Relationship:		**Relationship:**
Diabetes	_____	High Blood Pressure	_____
Heart Attack	_____	Breast Cancer	_____
Stroke	_____	Colon Cancer	_____
Tuberculosis	_____	High cholesterol	_____
Alzheimer's	_____	Melanoma (skin cancer)	_____
Prostate Cancer	_____	Ovarian Cancer	_____ _____

3. **LIFESTYLE HISTORY**

A. **Smoker** (currently): YES / NO Number packs per day: _____ Number of years smoking: _____
If ex-smoker, when did you quit: _____

B. **Alcohol intake**:
What do you usually drink? _____ How much?: _____ How often? _____
Do not drink alcohol _____

C. **Exercise**:
Do you exercise regularly? _____ What activities? _____

D. **Diet**: Check any foods you **AVOID** in your diet:
_____Salt _____Sugar _____Fats (oils) _____Red Meat _____Eggs _____Poultry _____Wheat _____Caffeine

Other: _____

Usual number of meals per day: _____ Number of times per week you eat "fast foods": _____

E. Travel
Have you recently travelled outside the U.S.? _____ Where? _____

F. Work
Current Occupation?: _____ Have you had any work related illnesses/injuries? _____
Injury/Illness While employed as:
_____ _____

Do you have a history of exposure to toxic chemicals or substances?: YES / NO
What?: _____ Where? _____ When?: _____

4. HEALTH MAINTENANCE

Date of last physical / annual exam: _____ Physician: _____

Date of last Pap smear: _____

Date of last Colonoscopy: _____

Date of last DEXA / Bone Density: _____

Date of last Mammogram: _____

Date of last Prostate Exam: _____

Date of last EKG: _____

Date of last Chest Xray: _____

Date of last annual blood work: _____

Do you use a seat belt in your car? YES / NO

5. REVIEW OF SYSTEMS

A. In the past, have you been diagnosed as having any of the following conditions? **Check and date**.

SYMPTOMS	DATE	SYMPTOMS	DATE
[ ] High Blood Pressure		[ ] Varicose Veins	
[ ] Hardening of the arteries		[ ] Phlebitis	
[ ] Heart attack		[ ] Migraine headaches	
[ ] Stroke or TIA		[ ] Cluster headaches	
[ ] Heart murmur		[ ] Tension headaches	
[ ] Angina		[ ] Congestive heart failure	
[ ] Cataracts		[ ] Glaucoma	
[ ] Sinusitis		[ ] Meniere's disease	
[ ] Nasal Polyps		[ ] Allergic rhinitis	
[ ] Tonsillitis		[ ] Gum Disease	
[ ] Cervical (neck) strain		[ ] Arthritis	
[ ] Lupus		[ ] Rheumatoid arthritis	
[ ] Emphysema		[ ] Chronic bronchitis	
[ ] Pneumonia		[ ] Asthma	
[ ] Fibrocystic breast disease		[ ] Galactorrhea (breast discharge)	
[ ] Hyperthyroidism (overactive)		[ ] Hypothyroid (low thyroid)	
[ ] Pernicious anemia		[ ] Lymphoma	
[ ] Peptic ulcer		[ ] Iron deficiency anemia	
[ ] Gastritis / Esophagitis		[ ] Giardia or other parasite	
[ ] Intestinal polyps		[ ] Malabsorption	
[ ] Diverticulosis		[ ] Chronic fatigue syndrome	
[ ] Irritable bowel		[ ] Enlarged prostate	
[ ] Reflux or GERD		[ ] Crohn's disease	
[ ] Fibromyalgia		[ ] Prostatitis (prostate infection)	
[ ] Ulcerative colitis		[ ] Pelvic Inflammatory disease	
[ ] Hemorrhoids		[ ] Uterine fibroids	
[ ] Epididymitis		[ ] Cystitis (bladder infection)	
[ ] Dysmenorrhea		[ ] Hepatitis A, B or C	
[ ] Vaginitis		[ ] Diabetes	
[ ] Pyelonephritis (kidney infection)		[ ] Gallstones	
[ ] Kidney stone		[ ] PMS or PMDD	
[ ] Hypoglycemia		[ ] Depression	
[ ] Bulimia or Anorexia		[ ] Multiple sclerosis	
[ ] Any type of cancer?		[ ] Panic attacks	
What type?		[ ] High cholesterol or triglycerides	
[ ] Abnormal xray findings		[ ] Sexual dysfunction	
Describe		[ ] Abnormal PAP smear	

B. Presently or in the past, have you had any of the following symptoms? **Check and date**.

SYMPTOMS	DATE	SYMPTOMS	DATE
[ ] Recurrent headaches		[ ] Weight loss # of pounds lost	
[ ] Fever (unexplained)		[ ] Chills	
[ ] Generalized fatigue		[ ] Generalized weakness	
[ ] Double vision		[ ] Ringing in ears	
[ ] Recurrent sinus infection		[ ] Recurrent sore throats	
[ ] Hoarseness		[ ] Neck stiffness	
[ ] Coughing up blood		[ ] Chronic cough	
[ ] Chest pressure / tightness on exertion		[ ] Chest pressure or tightness at rest	
[ ] Feeling dizzy or off-balance		[ ] Pain in legs while walking	
[ ] Change in appetite		[ ] Abdominal burning pain	
[ ] Nausea		[ ] Diarrhea	
[ ] Changes in bowel habits		[ ] Rectal bleeding	
[ ] Painful urination		[ ] Change in urinary habits	
[ ] Breast pain		[ ] Weight gain # of pounds gained	
[ ] Night sweats		[ ] Generalized body aches	
[ ] Change in vision		[ ] Change in hearing	
[ ] Frequent nosebleeds		[ ] Recurrent gum or tooth infection	
[ ] Constant sinus drainage		[ ] Trouble swallowing	
[ ] Swollen glands		[ ] Shortness of breath on exertion	
[ ] Shortness of breath while laying down		[ ] Cough up phlegm in the morning	
[ ] Feeling faint or almost passing out		[ ] Swollen ankles or feet	
[ ] Heartburn or indigestion		[ ] Abdominal cramping pain	
[ ] Vomiting		[ ] Constipation	
[ ] Blood in or on stool		[ ] Frequent or urgent urination	
[ ] Blood in urine		[ ] Vaginal discharge or odor	
[ ] Change in menstrual		[ ] Change in sexual desire	
[ ] Breast lump		[ ] Nipple discharge	
[ ] Testicular pain		[ ] Skin rash	
[ ] Easy bruising or bleeding		[ ] Changes in hair	
[ ] Trouble sleeping		[ ] Depression	
[ ] Muscle weakness or pain		[ ] Tingling in hands or feet	
[ ] Joint swelling		[ ] Testicular swelling	
[ ] Changes in skin or moles		[ ] Lumps in neck, underarms or groin	
[ ] Sensation of being too hot or too cold		[ ] Nervousness, panic	
[ ] Mood swings		[ ] Numbness	
[ ] Joint pains		[ ] Seizures or convulsions	
[ ] Head injury and loss of consciousness		[ ] Memory loss	

List any other problems not mentioned above: _____
_____

6. CHIEF COMPLAINT: Please list the main reason for your visit today and any other specific concerns or problems you want the doctor to discuss with you.

_____
_____

Acknowledgment of Privacy Consent Form

I hereby give consent to Terese A. Taylor, M.D. to use and disclose any protected health information for the purpose of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by request.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant you request, but if we do the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on behalf and delivered to 4202 Del Prado Blvd, Cape Coral, FL 33904. You may deliver your revocation by any means you choose, personally or by mail, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Signed: _____ Date: _____

Print Name of Patient: _____

If you are signing as the patient's representative:

Print Your Name: _____

Relationship to the Patient: _____

ADVANCED INTEGRATIVE MEDICINE

TERESE TAYLOR M.D.

Cosmetic Interest Questionnaire

Would you be interested in any of the following? (Check all that apply)

☐ **Chemical Peels**	☐ **Skin Care Products**	☐ **BioIdentical HRT**	☐ **Retin-A**
☐ **Botox**	☐ **Xeomin**	☐ **Dysport**	☐ **Restylane**
☐ **Perlane**	☐ **Juvederm Ulta**	☐ **Juvederm Ultra Plus**	☐ **Juvederm Voluma**
☐ **Belotero**	☐ **Radiesse**	☐ **Sculptra**	☐ **Latisse**

How did you hear about our practice?

☐ **Physician**	☐ **Friend / Family**	☐ **Seminar**	☐ **Insurance Co.**
☐ **Internet**	☐ **Email forwarded**	☐ **Advertisement or Article**	

If you were referred by one of our patients, please share his/her name so that we can thank him / her.

What cosmetic procedures, if any, have you had in the past? _____

Were you pleased with the outcome? If not, why?_____

If our office held a seminar for patients to learn more about certain cosmetic procedures, would you attend?
YES / NO

Thank you.

Phone: 239.540.9918 | **Fax:** 239-540-9921 | **Address:** 4202 Del Prado Blvd. S., Cape Coral FL, 33904
www.DrTereseTaylor.com

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care / diagnostic treatment and / or minor surgical treatment by Terese A. Taylor, M.D., deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past / current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ Date: _____

I, _____ give permission for the following individual(s) to have access to my medical information that is contained within my medical records.

Thay are as follows:

	Name	Relation to Patient	Which records? (all, limited)
1.			
2.			
3.			
4.			
5.			
6.			

This notice acts as an addition to the individual HIPAA notice as an addendum to those having the ability to have access to the aforementioned's medical information.

Patient signature: _____ Date: _____

Witnessed by: _____

Witness signature: _____

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MEDICAL RECORDS RELEASE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient Name:_____ Date of Birth: _____

Social Security Number: _____ Telephone #: _____

Address: _____

Please send my records to:
Terese A. Taylor, M.D.
4202 Del Prado Blvd.
Cape Coral, FL 33904
Fax: 239-540-9921

Purpose of Request: _____

Treatment Dates: _____

The following information is to be disclosed:

_____ Physician Notes _____ X rays _____ Lab Results
_____ MRI / CT Scans _____ Correspondence _____ Complete Records
_____ Other: _____

From Dr.: _____Fax: _____

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to STD's, AIDS, or infection with HIV. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if the authorization is needed for participation in a research study, my enrollment in the study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition (or if you do not specify a date, event or condition this authorization will expire in one year).

SIGNATURE OF PATIENT: _____DATE: _____

If signed by a legal representative, please specify your relationship to the patient: _____