



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: _____

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:

| <u>Relationship:</u> | <u>Relationship:</u> |
|-----------------------|------------------------------|
| 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.**

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



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

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

Cosmetic Interest Questionnaire

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

-
- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Bioidentical HRT | <input type="checkbox"/> Retin-A |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Xeomin | <input type="checkbox"/> Dysport | <input type="checkbox"/> Restylane |
| <input type="checkbox"/> Perlane | <input type="checkbox"/> Juvederm Ultra | <input type="checkbox"/> Juvederm Ultra Plus | <input type="checkbox"/> Juvederm Voluma |
| <input type="checkbox"/> Belotero | <input type="checkbox"/> Radiesse | <input type="checkbox"/> Sculptra | <input type="checkbox"/> Latisse |
-

How did you hear about our practice?

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Friend / Family | <input type="checkbox"/> Seminar | <input type="checkbox"/> Insurance Co. |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Email forwarded | <input type="checkbox"/> 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.

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.

They 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: _____

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: _____