ADVANCED INTEGRATIVE MEDICINE
TERESE TAYLOR M.D.

NEW MEDICAL PATIENT REGISTRATION FORM

Date: _____ Social Security #: _____

PATIENT NAME (Last, First, M.I.): _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ E-Mail (legibly please): _____

Employer: _____ Occupation: _____

Employer Phone: _____

Pharmacy Name & Phone #: _____

SPOUSE OR SIGNIFICANT OTHER

Name: _____ Cell Phone: _____

Home Address: _____

Employer: _____ Work Phone: _____ _____

EMERGENCY CONTACT & REFERRAL

In Case of Emergency, Notify: _____

Relationship: _____ Phone: _____

Referred to our office by: _____

6360 Presidential Court, Suite 5A, Fort Myers, FL 33919 | **P:** 239.540.9918 | **F:** 239.673.1505

www.DrTereseTaylor.com

ADVANCED INTEGRATIVE MEDICINE
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COMPLETE MEDICAL HISTORY FORM

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

1. PAST MEDICAL HISTORY

A. Surgeries:

T & A (tonsils) Date: _____ Hysterectomy Date: _____

Appendectomy Date: _____ Ovaries Removed? 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: _____

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F. Immunizations: Check Childhood Shots Given:

DPT: _____Mumps: _____ Rubella: _____Polio: _____ Smallpox: _____

Tetanus Booster	Date: _____
Pneumovax (pneumonia vaccine)	Date: _____
Influenza	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	_____	Melanoma (skin cancer)	_____
Prostate Cancer	_____	Ovarian Cancer	_____

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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

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: _____

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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	
[ ] Panic attacks		[ ] High cholesterol or triglycerides	
[ ] Sexual dysfunction		[ ] Abnormal PAP smear	
[ ] Any type of cancer? What type?			
[ ] Abnormal xray findings Describe			

B. Presently or in the past, **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 lying 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 concerns or problems you want the doctor to discuss with you.

_____
_____

ADVANCED INTEGRATIVE MEDICINE

TERESE TAYLOR M.D.

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 your behalf and delivered to 6360 Presidential Court, Suite 5A, Fort Myers, FL 33919.. 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: _____

f you are signing as the patient's representative:

Print 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**
- ☐ **Bioldentical HRT**
- ☐ **Retin-A**
- ☐ **Botox**
- ☐ **Xeomin**
- ☐ **Dysport**
- ☐ **Restylane Family**
- ☐ **Juvederm Family**
- ☐ **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

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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, _____ permit 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 patient's medical information.

Patient signature: _____ Date: _____

Witnessed by: _____Witness signature: _____

ADVANCED INTEGRATIVE MEDICINE

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MEDICAL RECORDS RELEASE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use and 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.
6360 Presidential Court, Suite 5A,
Fort Myers, FL 33919.
Fax: 239.673.1505

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: _____