Mary M. Colburn, M.D., P.A.

Geriatric Medicine
Internal Medicine

400 Executive Center Drive, Suite 102
West Palm Beach, FL 33401

(561) 683-2220
Fax (561) 683-3885

Date: _____

Dear _____:

An appointment is scheduled for you to see Dr. Colburn on _____ at 1:00pm. Enclosed is the Patient Information packet. Please bring the following to your appointment:

- Completed Patient Information Packet
- Prescription and Non-prescription (over-the-counter) medication **bottles** including: herbal supplements, vitamins, lotions, ointments and/or eye drops
- Original Photo Identification (Current Driver's License or Identification Card)
- Original Insurance Cards (Medicare and Supplemental or Secondary Insurance Cards) No copies allowed.
- If applicable, Advance Directives for example:
  - Living Will
  - Health Care Surrogate
  - Durable Power of Attorney
  - Do Not Resuscitate Order
- List of questions or concerns
- If applicable, copies of Medical Records

Respectfully, your appointment will be rescheduled if the above information is incomplete. Please dress comfortably wear a short sleeve shirt, bring a sweater in case you get cold and wear flat shoes. Please arrive at the office at least 15 minutes prior to your scheduled appointment time. If you have any questions about this information or anything else regarding your appointment, please do not hesitate to call the office at (561) 683-2220. We look forward to meeting you.

Patient Information

Please Print Clearly:

Name:_____ Date of Appointment:_____

Social Security Number:_____ Date of Birth:_____

Address:_____ City: _____ State:_____ Zip Code:_____
(Street Address)

Phone Number:_____ Cell Phone :_____ Fax Number:_____

If applicable, other residence address & phone number(s):

Address:_____ City: _____ State:_____ Zip Code:_____
(Street Address)

Phone Number:_____ Cell Phone :_____ Fax Number:_____

Recommended by:_____

If applicable, spouse's name:_____

Emergency Contact: _____

Relationship to Patient:_____

Address:_____ City: _____ State:_____ Zip Code:_____
(Street Address)

Phone Number:_____ Cell Phone :_____ Fax Number:_____

Emergency Contact: _____

Relationship to Patient:_____

Address:_____ City: _____ State:_____ Zip Code:_____
(Street Address)

Phone Number:_____ Cell Phone :_____ Fax Number:_____

Billing and Insurance Information

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Guarantor (if different than patient):

Name:_____ Relationship to Patient:_____

Address:_____ City: _____ State:_____ Zip Code:_____
(Street Address)

Phone Number:_____ Cell Phone :_____ Fax Number:_____

Billing Address (if different than mailing address):

Address:_____ City: _____ State:_____ Zip Code:_____
(Street Address)

Phone Number:_____ Cell Phone :_____ Fax Number:_____

Attention to:_____

Health Insurance:

Medicare Number:_____

Supplemental or Secondary Insurance:_____

Authorization for Payment of Services

- I authorize direct payment of medical benefits to Mary M. Colburn, M.D., P.A.
- I authorize Mary M. Colburn, M.D., P.A. to release any information required by my health insurance company to process claims.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I understand payment for services are due when rendered.
- A photostatic copy of this authorization will be as valid as the original.

Signature of Patient
or Responsible Party:_____ Date:_____

Doctor(s) List - Florida

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

The following information will assist Dr. Colburn in obtaining medical information and/or contacting other physicians. Please complete for all doctors you have seen in the past and are seeing on a regular basis.

Primary Care Physician	**Ears, Nose & Throat**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Cardiologist	**Gastroenterologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Dermatologist	**Gynecologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Endocrinologist	**Hematologist/Oncologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )

Doctor(s) List - Florida

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

The following information will assist Dr. Colburn in obtaining medical information and/or contacting other physicians. Please complete for all doctors you have seen in the past and are seeing on a regular basis.

Neurologist	**Pulmonologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Ophthalmologist	**Rheumatologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Orthopaedic Surgeon	**Surgeon**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Podiatrist	**Urologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )

Doctor(s) List - Not Local to Florida

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

The following information will assist Dr. Colburn in obtaining medical information and/or contacting other physicians. Please complete for all doctors you have seen in the past and are seeing on a regular basis.

Primary Care Physician	**Ears, Nose & Throat**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Cardiologist	**Gastroenterologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Dermatologist	**Gynecologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Endocrinologist	**Hematologist/Oncologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )

Doctor(s) List - Not Local to Florida

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

The following information will assist Dr. Colburn in obtaining medical information and/or contacting other physicians. Please complete for all doctors you have seen in the past and are seeing on a regular basis.

Neurologist	**Pulmonologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Ophthalmologist	**Rheumatologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Orthopaedic Surgeon	**Surgeon**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )
Podiatrist	**Urologist**
Doctor's Name:	Doctor's Name:
Address:	Address:
City: State: Zip Code:	City: State: Zip Code:
Phone Number:( )	Phone Number:( )
Fax Number:( )	Fax Number:( )

Directions to Dr. Colburn's Office

Address: 400 Executive Center Drive, Suite 102
West Palm Beach, FL 33401
Phone Number: 561-683-2220
Fax Number: 561-683-3885

Directions to office from the North:
I-95 south to Palm Beach Lakes Blvd. Palm Beach Lakes Blvd left (east) to Congress Ave. Congress Ave. right (south) to Executive Center Drive left (east) on Executive Center Drive. Drive approximately ⅓ mile. Our building will be on the left (north) side of street. Drive past the building to Presidio Place, turn left (north) on Presidio Place. Turn left at the first driveway.

Directions to office from the South:
I-95 north to Palm Beach Lakes Blvd. Palm Beach Lakes Blvd right (east) to Congress Ave. Congress Ave right (south) to Executive Center Drive left (east) on Executive Center Drive. Drive approximately ⅓ mile. Our building will be on the left (north) side of street. Drive past the building to Presidio Place, turn left (north) on Presidio Place. Turn left at the first driveway.

Directions from the East:
Palm Beach Lakes Blvd west to Congress Ave. Congress Ave left (south) to Executive Center Drive left (east) on Executive Center Drive. Drive approximately ⅓ mile. Our building will be on the left (north) side of street. Drive past the building to Presidio Place, turn left (north) on Presidio Place. Turn left at the first driveway.

Directions from the West:
Palm Beach Lakes Blvd east to Congress Ave. Congress Ave right (south) to Executive Center Drive left (east) on Executive Center Drive. Drive approximately ⅓ mile. Our building will be on the left (north) side of street. Drive past the building to Presidio Place, turn left (north) on Presidio Place. Turn left at the first driveway.

Mary M. Colburn, M.D., P.A.
400 Executive Center Drive, Suite 102
West Palm Beach, FL 33401
Phone #: (561)683-2220
Fax #: (561)683-3885

Authorization to Release Medical Information

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

To Whom It May Concern:

I, the under signed, do hereby authorize any hospital, physician or other person who has attended to me or examined me to furnish Mary M. Colburn, M.D., P.A. any and all information with respect to any illness or injury, medical history (including, if applicable, mental health or psychiatric records), consultation, prescription or treatment, and copies of all hospital or medical records (or photostats thereof). A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient
or Responsible Party:_____ Date:_____

Mary M. Colburn, M.D., P.A.

Geriatric Medicine
Internal Medicine

400 Executive Center Drive, Suite 102
West Palm Beach, FL 33401

(561) 683-2220
Fax (561) 683-3885

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment to protecting health information about you

In this Notice, we describe the ways that we may use and disclose health information about our patients. The **Health Insurance Portability and Accountability Act or HIPAA** Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called **"Protected Health Information" or PHI**. This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy of PHI about you
- Give you this Notice of our legal duties and privacy practices with respect to PHI
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our **HIPAA Point Person or HPP**.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the secretary of the United States Department of Health and Human Services. To file a complaint with our office, please contact our HPP. We will not retaliate or take action against you for filing a complaint.

Questions and HPP

If you have any questions about this Notice, please contact our HPP, Barbara Tolson, Office Manager at the address and telephone number listed above.

This Notice was published and first became effective on April 14, 2003

Notice of Privacy Practices

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

I. Who We Are:

This notice describes the privacy practices of Mary M. Colburn, M.D., P.A., including Dr. Mary M. Colburn, her employees and volunteers; who together are sometimes called "we" in this notice.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("**Protected Health Information**" of "**PHI**") and to provide you with this Notice of our legal duties and privacy with respects to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situation, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV. D below), in order to treat you, obtain payment for services provided to you and conduct our "health care operations" as detailed below:

- **Treatment.** We may use and disclose your PHI to facility personnel and attending physicians for use in connection with the treatment and other services to you – for example, to diagnose and treat your injuries or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

- **Payment.** We may use and disclose your PHI to obtain payment for services that we provide to you from Medicare, the Florida Medicaid program or another governmental program that arranges or pays the cost of some or all of your health care or to verify that such program will pay for health care. We will obtain your authorization to disclose PHI to your private health insurer, or other private payer.

- **Health Care Operations.** We may use and disclose you PHI for our health care operation, which include risk management, internal administration and planning various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physician, nurse, and other health care workers. We may disclose PHI to our **HIPAA Point Person (HPP)** in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. In addition, we may share PHI with our business associates who perform treatment, payment and health care operations services on our behalf.

B. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close friend or any other person identified by you when you are present for, or otherwise available prior to, disclosure, if we (1) obtain your agreement or instructions to establish a health care surrogate under applicable Florida law; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree to or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest in accordance with Federal and Florida law. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your heath care. Furthermore, if your capacity to make health care decisions for yourself or to provide informed consent is in question, we will notify your health care surrogate or attorney-in-fact in writing that her or his authority under the instrument has commenced, as provided under applicable Florida law.

C. Public Health Activities. We may disclose you PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to the Florida Department of Children and Family Services or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, exploitation or domestic violence, we may disclose your PHI to the Florida Department of Children and Family Services, the Florida Department of Human Services or a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceeding. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. Further, unless specifically authorized by a court order, we may not use os disclose PHI identifying you as a recipient of substance abuse program services if the purpose is to initiate or substantiate any criminal charges against you or to conduct any investigation of you. If we do not receive a legal order, we may disclose your PHI in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if : (in) we receive satisfactory assurance from the party seeking the PHI that reasonable efforts have been made by such party to secure a qualified protective order.

G. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials including any Florida administrative or regulatory agency, department, or other governmental authority with jurisdiction over health care providers or hospital facilities as required or permitted by Federal or Florida law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedent. We may disclose you PHI to a coroner or medical examiner as authority by law.

I. Organ and Tissue Procurement. We may disclose you PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

J. Health or Safety. We may use of disclose you PHI to prevent or lessen a serious imminent threat to a person's or the public's health or safety as permitted or required by Florida law.

K. Specialized Government Functions. We may use and disclose your PHI to units of the government with special function, such as the U.S. military or the U.S. Department of State under certain circumstances as permitted or required by law.

L. Workers' Compensation. We may use and disclose your PHI as authorized by and to the extent necessary to comply with Florida law relating to workers' compensation or other similar programs.

M. As Required by Law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, we may only use your PHI when you grant us your written authorization on our authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

B. Payment. We must obtain Your Authorization to disclose PHI to your health insurer or other private payer to obtain payment for services that we provide to you.

C. Marketing. We must also obtain Your Authorization prior to using your PHI to send you any marketing materials or utilizing your PHI for solicitation or marketing the sale of goods or services.

D. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of you PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and development disabilities services; (3)is about alcohol and drug abuse prevention, treatment, and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about genetic testing; (6) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain Your Authorization.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information : Complaints. If you desire further information about your privacy rights, are concerned that we have violated your rights or disagree with a decision that we made about access to you PHI, you may contact the HPP. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the HPP will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment, and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

To request restrictions, you must make your request in writing to our HPP. In your request, please include (1) the information you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); and (3) to whom you want those restrictions to apply.

C. Right to Receive Confidential Communications. You may request, and we will accommodate any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke Your Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the HPP.

E. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the HPP and submit the completed form to the Hospital Privacy Office. If you request copies, we will charge you $1.00 for each paper page up to 25 pages and 0.25¢ per page over 25 pages. We will also charge you for our postage costs, if you request that we mail the copies to you.

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from our HPP and submit the completed form to the HPP. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. There may be an additional charge if you request an accounting more than once during a twelve (12) month period.

Acknowledgment of Receipt of Notice of Privacy Practices

Patient's Name:_____

I acknowledge that I have received the Notice of Privacy Practices from the office of Mary M. Colburn, M.D., P.A..

_____ _____

Signature of Patient or Representative Date

If signed by a representative, what is your relationship to the patient:_____

Medication Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Pharmacy Information

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(Street Address)

Phone Number: _____ Fax Number: _____

Local Pharmacy if different from above:

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(Street Address)

Phone Number: _____ Fax Number: _____

Please circle the appropriate answer to the following questions:

Do you have a prescription medication plan?	Yes No	If yes, what plan? How many months supply of medication are you allowed?
Do you use a weekly medication box?	Yes No	
Does anyone help you with your medications?	Yes No	If yes, who?

Medication Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Date:_____

Allergic and Adverse Reactions to Medications

Please list any allergic and adverse reactions to medications, including prescriptions, supplements and over the counter medications:

Medication(s)	Describe the reaction:

Medication Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Date: _____ **Medications** Page 1 of _____

Please complete the following information:

Medication(s) including non-prescription medication(s) (over-the-counter) **List Prescriptions first**	Dosage (Strength)	How are you taking it? (Frequency)	Who Prescribed?	Why do you take it? (Illness or Condition)	How long have you taken it?

Medication Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Medications

Please complete the following information:

Medication(s) including non-prescription medication(s) (over-the-counter) **List Prescriptions first**	Dosage (Strength)	How are you taking it? (Frequency)	Who Prescribed?	Why do you take it? (Illness or Condition)	How long have you taken it?

Medication Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Medications

Please complete the following information:

Medication(s) including non-prescription medication(s) (over-the-counter) **List Prescriptions first**	Dosage (Strength)	How are you taking it? (Frequency)	Who Prescribed?	Why do you take it? (Illness or Condition)	How long have you taken it?

Health Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please list any **Hospitalization(s)** for Major Illness or Surgery:

Major Illness or Surgery (Including your childhood & Cataracts)	Year	Hospital Name, Address & Phone Number

Health Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please circle the appropriate answer to the following questions:

Do you have or have you had **High Blood Pressure**? If yes, when were you diagnosed? _____	Yes No
Have you had a **Stroke**? If yes, when?_____	Yes No
Have you had a **TIA or "mini-stroke"**? If yes, when?_____	Yes No
Have you had a **Heart Attack**? If yes, when?_____	Yes No
Have you ever had a **stress test** of your heart? If yes when?_____	Yes No
Do you have or have you had **Rheumatic Fever**?	Yes No
Do you have or have you had **Asthma, Bronchitis** or **Emphysema**? If yes, when were you diagnosed? _____	Yes No
Do you have or have you had **Tuberculosis**? If yes, when?_____	Yes No
Do you have or have you had **Gall Bladder Disease**? If yes, when?_____	Yes No
Do you have or have you had **Ulcers**? If yes, when?_____	Yes No
Do you have or have you had **Liver Disease (Jaundice, Hepatitis)**? If yes, when?_____	Yes No
Do you have or have you had **Urinary Tract Infection(s)**? If yes, when?_____	Yes No
Do you have or have you had **Gonorrhea or Syphilis**? If yes, when?_____	Yes No
Do you have or have you had **Anemia**? If yes, when were you diagnosed? _____	Yes No

Health Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Do you have or have you had **Arthritis**? If yes, where and since when?_____ _____	Yes No
Do you have or have you had **Gout**? If yes, when?_____	Yes No
Do you have **Diabetes**? If yes, when were you diagnosed? _____	Yes No
Do you have or have you had **Thyroid Disease**? If yes, is your thyroid **underactive** or **overactive**?_____ If yes, when were you diagnosed? _____	Yes No
Do you have or have you had **Seizures (Fits or Convulsions)**? If yes, when?_____	Yes No
Do you have or have you had **Nervous Breakdown**? If yes, when?_____	Yes No
Do you have **Suicidal Thoughts** or have you had **Suicide Attempt**? If yes, when?_____	Yes No
Do you have or have you had **Depression**? If yes, when?_____	Yes No
Do you have or have you had **Cancer**? If yes, when?_____ What type?_____	Yes No
Did you ever have **radiation therapy** of the head or neck?	Yes No
Do you have or have you had **Cataracts?** If yes, since when? _____	Yes No
Do you have or have you had **Macular Degeneration**? If yes, since when? _____	Yes No

Health Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Do you have or have you had **Glaucoma**? If yes, since when? _____	Yes No
Do you or have you ever smoked **cigarettes**? If yes, since what age did you start? _____ How many cigarettes did or do you smoke per day? _____ If you stopped, what age did you stop?_____	Yes No
Do you or have you ever taken **illegal substances**, such as marijuana cocaine? If yes, since when?_____ If you stopped, when?_____	Yes No
Do you consume any **alcoholic beverages**? If yes, how many per week? _____ Has alcohol ever been a problem?	Yes No Yes No
Are you currently **driving**? If yes, any concerns?_____ Any accidents within the past year? If yes, what happened?_____ _____	Yes No Yes No
Do you drink **coffee, tea or cola**? If yes, is the coffee, tea or cola decaffeinated?	Yes No Yes No
Have you had any contact with **dust, fumes, gases, chemicals, radiation or asbestos**?	Yes No
Did anyone help you complete this questionnaire? If yes, who:_____	Yes No

Review of Systems

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please circle the appropriate answer for the following questions:
Have you had in the past 3 (three)months or do you now have:

Weight change of more than 10 pounds in less than six months?	Yes No
Skin trouble?	Yes No
Eye or vision problem?	Yes No
Do you wear glasses? If yes, are your glasses single focal, bifocal or trifocal?_____ Do you wear glasses for distance or reading? _____	Yes No
Ear or hearing problem?	Yes No
Runny nose?	Yes No
Sinus problem?	Yes No
Nose problem?	Yes No
Headaches?	Yes No
Head trauma at any time in your life?	Yes No
Change in voice?	Yes No
Mouth problem?	Yes No
Problems with your teeth?	Yes No
Trouble swallowing?	Yes No
Cough?	Yes No
Coughing up blood?	Yes No
Wheezing?	Yes No
Difficulty breathing with exertion?	Yes No
Chest pain or chest discomfort?	Yes No
Palpitations or fast heart beat?	Yes No

Review of Systems

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please circle the appropriate answer for the following questions:
Have you had in the past 3 (three)months or do you now have:

Swollen legs or feet?	Yes No
Leg cramps?	Yes No
Discomfort in legs while walking?	Yes No
Pain in calves or legs while walking?	Yes No
Trouble walking?	Yes No
Balance problems?	Yes No
Falls: Have you fallen in the past 12 months? If yes, how many times have you fallen? Describe the circumstances of your last fall:_____ _____ _____	Yes No
Do you use a cane, walker or wheelchair? If yes, which item(s) do you use? _____	Yes No
Abdominal pain or heartburn?	Yes No
Vomiting of blood?	Yes No
Describe your appetite:	
How often do you move your bowels?	
Any change in your bowel movements? If yes, describe:_____ _____	Yes No

Review of Systems

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please circle the appropriate answer for the following questions:
Have you had in the past 3 (three)months or do you now have:

Diarrhea?	Yes No
Constipation?	Yes No
Black or bloody stool?	Yes No
Pain or burning on urination?	Yes No
Trouble starting or stopping urine?	Yes No
Do you get up to urinate at night? If yes, the number of times?_____	Yes No
Do you leak urine?	Yes No
When you feel the need to urinate do you need to get to the toilet quickly?	Yes No
Joint or muscle pains? If yes, describe and give location:_____ _____	Yes No
Numbness?	Yes No
Temporary loss of vision, speech or strength?	Yes No
Loss of consciousness (black-out)?	Yes No
Problems with memory?	Yes No
Confused?	Yes No
Forgetful?	Yes No
Do you have any relationships with people (family, spouse, children) that upset you?	Yes No
Anxious, nervous, panicky?	Yes No
Have you ever considered taking your own life?	Yes No

Review of Systems

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please circle the appropriate answer for the following questions:
Have you had in the past 3 (three)months or do you now have:

Do you have trouble with your sleep?	Yes No
What time do you go to bed?	
What time do you fall asleep?	
How many times during the night do you wake up?	
Are you able to fall asleep after waking up?	Yes No
What time do you get out of bed to start your day?	
Do you nap during the day? If yes, how many naps per day do you take? _____ What is the average length of your naps?_____	Yes No
Do you feel rested when you wake up?	Yes No
Are you sexually active? If yes, any concerns?_____	Yes No
Do you exercise on a regular basis? If yes, describe the activity, frequency and duration: _____ _____ _____	Yes No

Review of Systems

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Please circle the appropriate answer for the following questions:
Have you had in the past 3 (three)months or do you now have:

Women Only Age of menopause: _____ Did you ever take hormones? If yes, for how long? _____ Have you had in the past or do you now have: A breast lump or discharge? A breast biopsy? Vaginal bleeding since menopause? Vaginal discharge, itching or sore?	 Yes No Yes No Yes No Yes No Yes No
Men Only Have you had in the past or do you now have: A discharge from or sore on your penis? Difficulty having an erection?	 Yes No Yes No
Did anyone help you complete this questionnaire? If yes, who:_____	Yes No

Review of Systems

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Activity Screen

Please write down everything you do during a typical day.

Morning	Amount of Time
Afternoon	**Amount of Time**
Evening	**Amount of Time**
Night	**Amount of Time**

Review of Systems

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Nutritional Screen

Please write down everything you eat and drink, including the amount, on a typical day.

Breakfast	Amount
Lunch	**Amount**
Dinner	**Amount**
Snack(s)	**Amount**

General Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Describe your Family's medical history:

	Age of Death	Cause of Death	Medical Problems
Father			
Mother			

Brother(s) & Sister(s) (If deceased, age of death and cause of death)			
Name	**Age or Age of Death**	**If applicable, Cause of Death**	**Medical Problems**

General Information Questionnaire

Patient's Name:_____

Social Security #:_____ Date of Birth:_____

Why did you schedule an appointment with Dr. Colburn?

_____

_____

_____

_____

Where were you born?

Where did you grow up?

Describe your childhood:

_____

_____

_____

_____

Describe your relationship with your parents:

_____

_____

_____

What is your educational level?_____

_____

General Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Are you currently employed? _____
If yes, where? _____
If no, did you previously work outside of your home responsibilities? _____
Describe your employment experience: _____

Are you retired? _____
If yes, what year did you retire? _____
If yes, how old were you when you retired? _____

Did you marry? _____
How old were you when you married? _____
Are you still married? _____
If no, are you widowed or divorced? _____
If widowed, when did your spouse die? _____
If divorced, when? _____

Describe your marriage: _____

General Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

If you have married more than once, how many times and duration of each marriage and how the marriage ended:

_____

_____

_____

_____

_____

_____

_____

Do you have a unmarried live-in companion or significant other? _____
What is your sexual orientation? _____

Do you have any children?
If yes, list your children's names and ages and if you have any grandchildren:

_____

_____

_____

_____

_____

General Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Describe your relationship with your children:

What is your spiritual affiliation? _____

Describe your current emotional support system:

Describe any significant life events:

General Information Questionnaire

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

Describe any recent life changes:	
Did anyone help you complete this questionnaire? If yes, who: _____	Yes No

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