Progressive Medical Associates, PLLC
13220 Rosedale Hill Ave.
Huntersville, NC 28078
Phone: 704-766-0320 Fax: 704-766-0407

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Last, First): _____ Date of Birth: _____

Social Security Number: _____

I hereby request that my Medical Records be released to my Primary Care provider as follows:

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Huntersville, NC 28078
Phone: (704) 766-0320
Fax: (704) 766-0407

Information to be Disclosed:

□ Complete Medical Record

OR

□ Progress Notes
□ Mental Health Records
□ Diagnostic Records Pertaining to _____
□ Lab Results
□ X-ray Reports
□ Hospital Records of Admission for Dates: _____to_____
□ Other: _____

I understand:

- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- Authorization for disclosures shall not condition treatment, payment, or eligibility for benefits. I may refuse to sign this authorization.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Representative Relationship of Patient Representative
(If signed by someone other than the patient)

ANNUAL WELLNESS

Name: _____ DOB: _____ Date**:** _____

Sex Assigned At Birth: _____ Gender: _____

Has anything changed <u>in regards to your health</u> in the past year? *(New illness, surgeries, new medication allergies or intolerances, etc.)* _____

Have there been any significant changes in your life in the past year such as i*ncreased stress, new job, home, relationship, children, ill relatives, etc.?*

_____

Have any of your blood relatives developed any new illnesses in the past year? If any blood relative has had cancer, please list their relation to you, what they had, and how old they were when diagnosed:

_____

If you have had any vaccines in the past year, please list them & the approximate date(s):

_____

What is your occupation:_____ Spouse's occupation:_____
If you have children, what are their names & ages? _____
Do you currently use tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how much do you smoke (use) daily? _____
If no, have you ever used tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit_____
Any exposure to secondhand smoke (others smoking around you) currently or in the past? ❑Yes ❑ No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑ No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑ No If yes, what do you do for exercise and how often? _____
Please describe your diet _____
What do you and your partner use for contraception (*if applicable)*? _____
Have you had a new sexual partner in the past year? ❑Yes ❑ No
Would you like to be tested for HIV or other STDs? ❑Yes ❑ No
Do you see a dentist at least once a year? ❑Yes ❑ No

<u>HEALTHCARE WISHES</u>:

Do you already have a healthcare proxy or living will? ❑Yes ❑No Are you willing to be an organ donor? ❑Yes ❑No
Most healthy patients would like to be treated aggressively (CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? ❑Yes ❑ No ❑Not Sure
If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.
Name: _____Phone No: _____Relationship to You: _____
Name: _____Phone No: _____Relationship to You: _____

Please list any other physicians you are currently seeing:

<u>Name of Physician</u>	**<u>Location</u>**	**<u>Reason</u>**
_____		
_____		

NAME: _____ **DATE:** _____

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** ***(Please ✓the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off <u>any</u> problems listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Please **circle** your answer)*	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____