Apollo Healthcare Associates

Health History Questionnaire

Name: _____ DOB: _____

Instructions: Please answer all questions to the best of your ability. Circle all that apply, but leave blank if you are not sure.

Past Medical History

Wear Glasses/ Contacts	Deep Vein Thrombosis	Kidney Failure	Endometriosis	Bleeding Disorder
Cataracts	Varicose Veins	Diabetes type 1	Neurological Disease	Blood Transfusion
Glaucoma	Lung Disease	Diabetes type 2	Headaches	Breast Cancer
Diabetes Related Retinopathy	Asthma	Diabetes, Gestational	Seizures/Epilepsy	Lung Cancer
Other Eye Problem	COPD	PCOS	Stroke	Colon Cancer
Ear or Hearing Problems	Sleep Apnea	Obesity	Dementia	Ovarian Cancer
Chronic Ear Infections	Pulmonary Embolism	Hyperthyroidism	Joint Problem	Other Cancer
Allergies/ Hay Fever	GI problems	Hypothyroidism	Arthritis	Depression
Sinusitis	Difficulty Swallowing	Thyroid Nodule	Gout	Anxiety Disorder
Meniere's Disease	Reflux/GERD	Enlarged Thyroid	Muscle Problems	Eating Disorder
Vertigo	Gall Bladder Disease	Parathyroid Disease	Fibromyalgia	Mental disorder/illness
Heart Problems	Pancreatitis	Bone Problem	Skin Problems	ADD/ADHD
Coronary Artery Disease	Hepatitis	Osteoporosis	Eczema	Abuse/Domestic Violence
Heart Attack	Liver Disease	Low Testosterone	Chicken Pox	Hospitalizations
Atrial Fibrillation	Diverticulitis	Infertility	MRSA exposure	Vitamin Deficiency
Congestive Heart Failure (CHF)	Colon Polyps	Adrenal Insufficiencey	Tuberculosis	Other
Hypertension	Constipation	Cushing's Disease	AIDS/HIV	
Hyperlipidemia (High Cholesterol)	Bladder or Kidney Problems	Pituitary Disorder	Blood Diseases	
High Triglycerides	Kidney Stones	Hyperprolactinemia	Anemia	

Name: _____ DOB: _____

Surgical History:

Name of Surgery	Date

Family History:

Relative	Condition	Passed away from/age:
Father		
Mother		
Maternal Grandparents		
Paternal Grandparents		
Brother		
Sister		
Children		
Other		

Social History:

Exercise: Type: _____ Frequency: _____

Nicotine: Previous: _____ Quit Date: _____ Quantity: _____

Current: _____ Quantity: _____

Alcohol Frequency: _____ Quantity: _____

Pharmacy: _____ Lab: _____ Imaging Dept: _____

Medications:

Name of Medication	Dose	Times per day

Allergies:

	Reaction

Immunizations:

PCP: _____

Apollo Healthcare Associates

Review of Systems

Name: _____ DOB: _____

Please check yes or no as deemed appropriate regarding the following symptoms. If you are not sure, leave blank.

Yes	No	General
		Weakness
		Tiredness
		Lack of appetite
		Excess appetite
		Weight loss
		Weight gain
		Chills
		Fever
		Night Sweats
		Difficulty in sleeping

Yes	No	Eyes
		Decreased ability to see
		Blurred vision
		Eye pain
		Loss of peripheral vision

		Ears, Nose, Throat
		Difficulty in hearing
		Ringing in your ears
		Pain in your ear
		Discharge from the ears
		Nose Bleeds
		Runny nose
		Sneezing
		Post-nasal drip
		Sore throat
		Hoarseness
		Pain in the neck
		Dental trouble
		Bleeding gums

Yes	No	Allergic / Immunologic
		Hives
		Allergy Shots
		Eczema

Yes	No	Respiratory
		Dry cough
		Cough up phlegm
		Cough up blood
		Wheezing
		Asthma
		Shortness of breath at rest
		Shortness of breath with exertion
		Pain in chest when you cough, sneeze, or move

Yes	No	Cardiovascular
		Chest pain, tightness or pressure
		Shortness of breath, with activity
		Need to sit up to breathe
		Heart racing
		Irregular heart beat (palpitations)
		Heart murmur
		Swelling of the legs
		Varicose Veins
		Leg pain at rest
		Leg pain with exertion

Yes	No	Gastrointestinal
		Nausea
		Vomiting
		Diarrhea
		Constipation
		Heartburn
		Abdominal Pain
		Bright red blood in stools
		Black stools
		Change in bowel habits
		Food intolerance
		Need for antacids
		Hemorrhoids

Yes	No	Reproductive (Male)
		Testicular pain
		Lumps in testicles or scrotum
		Decrease in testicles size
		Decreased sexual libido

Name: _____ DOB: _____

Yes	No	Reproductive (Female)
		Do you ever bleed between periods?
		Decreased libido
		Have you had any vaginal bleeding since menopause?
		Are you bothered by hot flashes?
		Are you taking any female hormones?
		Age of onset of menstrual periods
		Age which periods stopped (menopause)

Yes	No	Endocrine
		Goiter
		Heat / cold intolerance
		Tremulousness of the hands
		Change in pitch of the voice
		Decrease / increase in body hair
		Breast pain or discharge
		Increased thirst
		Increased urination
		Marked increase in appetite

Yes	No	Musculoskeletal
		Painful joints
		Swelling of any joints
		Redness of any joints
		Stiffness of any joints
		Deformities of the joints or extremities
		Muscle pain
		Back pain
		Pain down the back of your legs

Yes	No	Skin
		Dryness of skin
		Itching
		Rash
		Change in skin color
		Change in texture of the hair
		Falling out of the hair
		Nail changes
		Skin ulcers

Yes	No	Urinary
		Urinary tract infections
		Pain or burning on urination
		Frequent urination-day
		Frequent urination-night
		Unusually large volumes of urine
		Extreme urge to urinate
		Difficulty starting urinary stream
		Difficulty stopping urinary stream
		Kidney stones

Yes	No	Psychiatric
		Nervousness
		Lack of interest
		Depression
		Anxiety
		Difficulty concentrating
		Thoughts of hurting yourself / others
		Difficulty in falling or staying asleep

Yes	No	Hematologic / lymphatic
		Easy bruising / bleeding
		Blood clots
		Lymphedema
		Anemia

Yes	No	Neurological
		Difficulty with memory for past events
		Difficulty with memory for recent events
		Difficulty with thinking or problem solving
		Headaches
		Blackouts
		Dizziness
		Double vision
		Paralysis or weakness of a limb(s)
		Loss of sensation
		Loss of balance
		Loss of coordination
		Difficulty in speaking
		Numbness / Tingling
		Tremors

Apollo Healthcare Associates LLC
General Consent for Treatment, Evaluation and Information Release

Patient Name: _____ **Date of Birth:** _____

_____
Initial

Notice of Privacy Practices. I acknowledge that I have reviewed the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact Apollo Healthcare Associates if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____
Initial

Release of Information. I hereby permit Apollo Healthcare Associates LLC to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be made available to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

_____
Initial

Consent to Treatment. I consent to evaluation and/or treatment that Apollo Healthcare Associates may deem necessary in the judgement of my health care provider. This may include, but is not limited to diagnostic, radiology, laboratory examinations and procedures, medical treatment and procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

_____
Initial

Consent for Photographing or Other Recording for Security and/or Health Care Operations: I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

_____ I hereby authorize that Apollo Healthcare Associates may leave messages at the phone numbers indicated below .
Initial

Number

- ☐ Home Phone Answering Machine or Voice Mail: _____
- ☐ Cell Phone Voice Mail: _____
- ☐ Cell Phone Text Message: _____
- ☐ Other Phone Voice Mail: _____

_____ I hereby authorize that Apollo Healthcare Associates may contact me at the following email address:
Initial

Email Address: _____

_____ I hereby authorize that Apollo Healthcare Associates may leave messages with other members of my household
Initial regarding my appointments or requests for me to contact the office.

_____ I hereby authorize that Apollo Healthcare Associates may disclose my health information to any person(s) who
Initial accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that Apollo Healthcare Associates may disclose my personal health information to the person
Initial who I have listed as my emergency contact.

Emergency Contact: _____ Phone Number: _____

_____ I hereby authorize that Apollo Healthcare Associates may disclose my personal health information for the
Initial purposes of communicating results, findings, and care decisions to the following persons listed below:

Name	Telephone Number	Relationship to Patient

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

_____ _____ _____ _____
Name of Patient Date Name of Authorized Representative Date

_____ _____ _____ _____
Signature of Patient Date Signature of Authorized Representative Date

Apollo Healthcare Associates LLC
Patient Financial Responsibility

Patient Name: _____ **Date of Birth:** _____

Thank you for choosing Apollo Healthcare Associates to serve as your health care provider. We are honored to participate in your health care and look forward to establishing a lasting relationship. Please read and sign this form to acknowledge your understanding of our patient financial policies.

_____ Initial **Cancellation Policy and Fees:** Failure to give 48 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $50. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, a minimum of 48 hours' notice is required. Failure to cancel three appointments with the necessary 48 hours' notification may result in discharge from our practice. Returned checks are subject to a $25 fee.

_____ Initial **Release of Information.** I hereby permit Apollo Healthcare Associates LLC (AHA) to release healthcare information for purposes of treatment, payment, or healthcare operations to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider

_____ Initial **Assignment of Benefits:** I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to AHA for all covered medical services and supplies provided to me during all courses of treatment and care provided by AHA and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with AHA, which will authorize and allow for direct payment to AHA of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by AHA.

_____ Initial **Financial Responsibility:** I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to AHA and/or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify AHA of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by AHA and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

_____	_____	_____	_____
Name of Patient	Date	Name of Authorized Representative	Date

_____	_____	_____	_____
Signature of Patient	Date	Signature of Authorized Representative	Date

Updated April 1, 2019

1326 Malabar Rd SE

Palm Bay | FL 32907-2501

mapquest

You can find our office on the south side of Malabar Rd, just east of the Malabar/Babcock intersection