Your Health District
FAMILY PRACTICE AND MEDSPA

MEDICAL HISTORY QUESTIONNAIRE | PATIENT INFORMATION

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

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Personal Email Address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

How were you referred to us? _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Reason for today's visit: _____

_____

TREATMENTS THAT INTEREST YOU

Please put a check mark next to the services that interest you.

- □ Primary Care
- □ Weight Loss
- □ Hormone Replacement
- □ Peptide Therapy
- □ Ozone Therapy
- □ IV Therapy
- □ Nutraceuticals
- □ Neurotoxin Injections (Botox/Xeomin/Dysport)
- □ Dermal Fillers
- □ Skin Resurfacing
- □ Chemical Peel/Facial
- □ Acne Treatments
- □ RF Microneedling
- □ Laser Hair Reduction

MEDICATIONS:

Please list all medications you are taking. Include prescribed and over the counter drugs, such as vitamins/inhalers, etc.

Drug Name: Strength: Frequency Taken:

Allergies: Reaction:

PAST MEDICAL HISTORY: Please check all that apply:

- □ Anxiety Disorder
- □ Arthritis
- □ Appendicitis
- □ Asthma
- □ Bleeding Disorder
- □ Blood Clots (or DVT)
- □ Cancer:
  Type(s):_____
- □ Coronary Artery Disease
- □ Diabetes - Insulin
- □ Diabetes - Non-Insulin
- □ Dialysis
- □ Diverticulosis/Diverticulitis
- □ Fibromyalgia
- □ Gallstones
- □ Gout
- □ Heart Attack
- □ Heartburn
- □ Heart Murmur
- □ Hiatal Hernia
- □ Hepatitis
- □ HIV or AIDS
- □ High Cholesterol
- □ High Blood Pressure
- □ Kidney Disease
- □ Kidney Stones
- □ Leg-Foot Ulcers
- □ Liver Disease
- □ Osteoporosis
- □ Pacemaker
- □ Peptic Ulcer Disease
- □ Pulmonary Embolism Stroke
- □ Thyroid Disorder
- □ Tuberculosis
- □ Other:_____

PAST SURGICAL HISTORY:

Type of Surgery

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____

FAMILY HEALTH HISTORY:

If any of the following family members have been diagnosed with Cancer (if so, what type), Diabetes, Heart Disease, Hypertension, or any other major disease/illness, please fill in the following:

	Disease(s)/Illness:
Mother	_____
Father	_____
Maternal Grandmother	_____
Maternal Grandfather	_____
Paternal Grandmother	_____
Paternal Grandfather	_____
Sibling (Circle): Brother/ Sister	_____
Sibling (Circle): Brother/ Sister	_____
Sibling (Circle): Brother/ Sister	_____
Sibling (Circle): Brother/ Sister	_____

IMMUNIZATION HISTORY:

□ Chickenpox	Date:_____	□ Meningcoccus	Date:_____
□ Flu Shot	Date:_____	□ MMR (Measles, Mumps, Rubella)	Date:_____
□ COVID	Date:_____	□ Pneumonia (Pneumovax)	Date:_____
□ Gardasil/HPV	Date:_____	□ Tdap (Tetanus/Diptheria/Pertussis)	Date:_____
□ Hepatitis A	Date:_____	□ Zostavax (Shingles)	Date:_____
□ Hepatitis B	Date:_____		_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY: Please Check All That Apply

Last PAP Smear Date:_____ □ Abnormal
Last Mammogram Date:_____ □ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause:_____
Do you get your period monthly? □Yes □ No
Flow: □ Light □ Moderate □ Heavy

Current Birth Control Method: _____
Number of Pregnancies: Abortions:_____
Miscarriages:_____Births:_____

□ Bleeding between periods
□ Extreme menstrual pain
□ Vaginal itching, burning, ordischarge
□ Wake up in the night to go to the bathroom
□ Hot flashes
□ Breast lump or nipple discharge
□ Painful intercourse

SOCIAL HISTORY:

Occupation:_____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner

Sexually Active: □ Yes □ No Do you use condoms? □ Yes □ No

Interested in being screened for STD's □ Yes □ No

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Stress Level: □ None □ Occasional □ Moderate □ Heavy

Smoking: □ Yes □ No If yes, # of packs per day? _____ Per Week?_____

Smoked Since Age: _____

Alcohol: □ None □ Occasional □ Moderate □ Heavy

Caffeine: □ None □ Occasional □ Moderate □ Heavy

Nicotine Products: □ None □ Once a day □ 2 - 4 Times a day □ 5+ Times a day

Drugs: Do you currently use recreational or street drugs? □ Yes □ No

If yes, please list:_____

SIGNATURE

I certify that the preceding medical and personal history statements are true and correct. I am aware that it is my responsibility to inform that practitioner of my current medical or health conditions and to update this history. A current medical history is essential for the provider to give the best care and execute appropriate treatment procedures.

Signature:_____Date:_____

Your Health District Policies

We ask that you please arrive 10-15 minutes prior to your appointment time. We will do our best to accommodate late arrivals. However, the length of service may be adjusted so as to not interrupt the scheduled appointments of other patients.

Please read and initial the following policies:

_____ **Payment** is due in full when services are rendered. We accept all major credit cards, debit cards, and cash.

_____ **Balances Owed:** Balances owed must be paid prior to receiving any further services. **BALANCES UNDER $50 WILL AUTOMATICALLY BE PAID USING THE CARD ON FILE.** It is the patient's responsibility to ensure YHD has the proper card on file.

_____ **Cancellation Policy:** Your appointments are reserved especially for you. We value your business and ask that you respect Your Health District's (YHD) scheduling policies. If you need to cancel or reschedule, please notify us at least 24 hours in advance. Any cancellations with less than 24 hours of notice are subject to a cancellation fee of $25. Clients who no show for appointments without giving any prior notification are subject to pay up to 50% of the scheduled service. When you schedule your appointment with us, you are agreeing to these policies.

_____ **Insurance:** YHD will bill your insurance as a courtesy. It is the patient's responsibility to understand coverage and benefits. YHD cannot guarantee coverage of your insurance claim or any specific insurance payment amounts.

_____ **Lab Services**: The physician may order laboratory services for you while you are in our facility. Although the samples are collected in this facility, we send to them to a third party lab (i.e. Lab Corp, Sonora Quest, etc.). The lab is responsible for all claims and billing to your insurance company. It is the patient's responsibility to understand their benefits, coverage and deductibles. YHD cannot guarantee coverage of your insurance claim or any specific insurance payment amounts.

_____ **Treatments & Packages:** Once services are purchased they will not be refunded, however, to ensure our clients always receive the greatest experience at YHD, unused service values (cash equivalent for the remaining amount of a treatment package) can be applied to any other service at YHD. To avoid abuse of special discounting with treatment/service packages, refunds on remaining un-used treatments will be given only after applying the full standard price of used treatments. All service packages and pre-paid treatments must be used within 12 months of date of purchase or they will expire. Gift certificates are non-refundable. We will, however, allow them to be transferred to another party. All injectable treatment sales are final; refunds or credits cannot be offered once treatment is completed.

_____ **Third Party Purchases:** Clients who have purchased our services from third parties (Groupon, LivingSocial, etc.) need to check the third party voucher for terms and conditions, as the terms or conditions of the deal/voucher will apply. Since third party entities are paid directly by the client, YHD cannot refund purchases made via a third party. However, notwithstanding the voucher terms of any third party, patients who are unsatisfied with the purchase, may redeem the remaining unused portion of the voucher for another service currently offered at YHD. Services that have already been rendered will not be redeemed again.

_____ **Products:** We are constantly striving to create an environment founded in excellence, quality, and most importantly - the safety of our clients. For this reason, we cannot accept product returns (with exception to defects in packaging or product) once your purchase has been completed.

All prices, policies and services are subject to change without notice.

Patient Signature:_____ **Date:**_____

Patient Name (Printed): _____

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Promedisch LLC or Your Health District LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Promedisch LLC and Your Health District to: (I) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Your Health District LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Print Name of Patient/Responsible Party

_____ _____
Patient/Responsible Party Signature **Date**

_____ _____
Parent/Guardian Signature **Relationship**