La Cholla Medical Group

PERSONAL MEDICAL HISTORY

MRN:_____
(admin use only)

_____ _____ _____ _____
Date Name Birthdate Age

Former PCP_____ **Office Name** _____ **Location**_____

What is the main reason for your visit today? _____

Please list your medications, include dosage and number per day:

	Medication	Dose	Frequency (x per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you currently taking any of the following nonprescription medications?

Aspirin? _____ Ibuprofen? _____ Tylenol? _____ Allergy Medication? _____ Laxatives? _____

Vitamins or Supplements? _____

Please list any medications you are allergic to and the reaction:

	Medication	Reaction
1.		
2.		
3.		

Are you on a special or modified diet? _____

Preferred Pharmacy and Location? _____

Mail Order Pharmacy? _____

What is/was your occupation? _____ **Spouse?** _____

Marital status? M-S-W-D _____ **Education?** High School/GED _____ College _____ Other _____

La Cholla Medical Group

PERSONAL MEDICAL HISTORY

MRN:_____
(admin use only)

Do you use tobacco? Yes ____ If so, how much? ____ No ____ Ex-Smoker, quit in year _____

Do you drink alcohol? Yes ____ No ____ Do you exercise? Yes _____ No _____ What? _____

List your chronic medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____

List any past surgeries and the year you had it done:

1. _____
2. _____
3. _____
4. _____
5. _____

Please indicate the year you may have had the following tests or vaccines:

Physical Exam_____ Pap Smear_____ Mammogram_____ Bone Density-DEXA_____

Colonoscopy_____ PSA/Prostate_____ EKG_____ Cholesterol_____ Audiogram/Hearing Test_____

Vaccines: Tetanus_____ Shingles_____ Pneumonia_____ Other Vaccines_____

FAMILY HISTORY

Family Member	Father	Mother	Grandparent	Brothers	Sisters
Diabetes					
High Blood Pressure					
Cancer (type)					
Heart Attack before age of 60					
Stroke before the age of 60					
Asthma					
Colon Polyps					
Other (specify)					

Please list other physicians you have seen in the last two years and reason:

_____

_____

_____

Arizona Community Physicians, P.C.
Adult
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

By providing the below phone '#'(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail_____ (Phone #)

DO NOT RELEASE Information to the following people: _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Patient/Guardian: _____ Signature _____Date_____

The information provided on this form will stay in effect until updated by the patient

Arizona Community Physicians P.C.
Authorization to Release Medical Information

Scan here to request your records online

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

Street Address _____

City/State/Zip_____

Phone # _____Fax#_____

To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization _____

Street Address _____

City/State/Zip_____

Phone # _____Fax#_____

Requested format ☐Paper ☐Disc (PDF format) ☐Email*_____

***Email option only available for medical records processed by CIOX.**

PURPOSE FOR THIS REQUEST **(Please check a box)**

☐At request of Patient ☐ Other* (specify) _____

***The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper. However, there may be additional charges for shipping and handling. Please do not submit payment with this request, you will receive a billing invoice.**

TYPE OF INFORMATION TO BE RELEASED **(No information will be released unless a box is checked)**

General Release DATES OF TREATMENT

☐ Medical Records/**Excluding Protected Records**

(This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) From_____ To_____

☐ Other Records (specify) _____ From_____ To_____

Information Protected by State/Federal Law

☐ All of my records including: From_____ To_____

AIDS/HIV and Other Communicable Disease Information,

Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

Signature of Patient or Personal Representative who may request Release of Medical Information: I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____ _____

Signature of Patient OR Legal Representative **Date** **Please Print Name of Signing Party**