PATIENT NAME: _____ **DATE OF BIRTH:** _____

WorldPath Health, Inc.
300 Mount Auburn Street SUITE 511
Cambridge MA 02138

PERSONAL AND CONFIDENTIAL
Fax Information to WorldPath Health Inc. 617 450-0051

DEMOGRAPHIC INFORMATION

Date: _____

Patient Name _____

Date of Birth (MM/DD/YYYY): _____ **Sex: Male** _____ **Female** _____

Telephone: Home: _____ **Mobile:** _____

Street Address. _____

City: _____ **State:** _____ **Zip Code:** _____

Country: _____ **Email:** _____

Marital Status: Married _____ Single _____ Widow(er) _____ Divorced _____

Ethnicity: _____

EMERGENCY CONTACT

Name: _____ **Relationship.** _____

Phone Number(s): _____

REFERRING PHYSICIAN

Name: _____ **Telephone:** _____

Address/Location _____

PRIMARY PHYSICIAN **(if different from referring physician):**

Name: _____ **Telephone:** _____

Address/Location _____

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MEDICAL INFORMATION

Height (inches) _____ Weight (pounds) _____ Recent Weight Loss? Y N Amount _____

Tobacco Use: Y N Current Prior Amount/Day _____

Alcohol Use: Y N Current Prior Amount/Day _____

Occupation: _____ # of Years: _____

Country of Residence: _____ # of Years: _____

Foreign Travel: Y N if yes, where and when: _____

_____

FAMILY HISTORY (use other side of this sheet if necessary)
List any medical conditions in close blood relatives

	LIVING (Y or N) ?	AGE	MEDICAL CONDITIONS
Father			
Mother			
Siblings			

_____

_____

_____

_____

_____

_____

_____

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MEDICAL INFORMATION
(use other side of page to complete if necessary)

Allergies: List any allergies that you have and describe the type of reaction:

Allergy	Type of Reaction

Medications: Please list all medications including hormone medications, herbal, vitamins etc.

Name of Medication	Dose	Frequency

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REVIEW OF SYSTEMS: Please tell us if you have any of the following symptoms:

Constitutional:	***Cardiovascular:***	***Immunologic:***	***Respiratory:***
___FEVER	____CHEST PAIN	___HAY FEVER	___SHORTNESS OF BREATH
___CHILLS	___IRREGULAR BEATS	___SKIN RASHES	___PAIN BREATHING
___NIGHT SWEATS	___PALPITATIONS	___LYMPHATIC:	___COUGH
___HEADACHES	___VALVE PROBLEMS	___SWOLLEN GLANDS	___WHEEZING
___WEIGHT GAIN	___HEART MURMUR	___SWELLING ARMS/LEGS	___SPUTUM

Neurological:	***Gastrointestinal:***	***Musculoskeletal:***	***Hematological:***
___TREMORS	___ABDOMINAL PAIN	___JOINTS HURT/STIFF	___ABNORMAL BLEEDING
___DIZZINESS	___NAUSEA/VOMITING	__BONE PAIN	___ABNORMAL BRUISING
___NUMBNESS	___HEARTBURN	___BACK/NECK PAIN	___ANEMIA
___STROKE	___SWALLOW DIFFICULTY	___WALKING DIFFICULTY	
___TIA	___JAUNDICE		
___FAINTING SPELLS	___ BLOOD IN STOOL		
___OTHER	___DIARRHEA		
	___ CONSTIPATION		

Genitourinary:	***Vascular***:	***Endocrine:***
___URINARY *PAIN*	___ULCER/GANGRENE	___EXCESSIVE THIRST
___URINARY FREQUENCY	___BLOOD CLOTS	___TOO HOT/COLD
___BLOOD IN URINE	___PAIN LEGS/FEET	____TIRED/SLUGGISH
		____HOT FLASHES

Other: (use other side of this sheet if needed): _____

_____

_____

_____

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PAST MEDICAL HISTORY

Please indicate any medical conditions that you have now or you have had in the past:

___ANEM	___GOUT	___OSTEOPOROSIS
___ANEURYSM	___GERD	___PANCREATITIS
___ARTHRITIS	___HEART DISEASE	___RHEUMATIC FEVER
___ASTHMA	___CANCER	___ DIABETES
___BLADDER INFECTION	___BLOOD TRANSFUSION	___ KIDNEY DISEASE
___HIGH BLOOD PRESSURE	___HIGH CHOLESTEROL	___OBESITY
___SEIZURES	___THYROID DISEASE	___ULCERS
___STROKE	___TUBERCULOSIS	

___ OTHER (PLEASE DESCRIBE) _____

PAST SURGICAL HISTORY: (use other side of this sheet if needed):

List all previous surgeries and when performed:

_____
_____
_____
_____
_____
_____
_____
_____

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MEDICAL INFORMATION

IF FEMALE:

AGE AT FIRST MENSTRUAL PERIOD: _____ **AGE AT MENOPAUSE:** _____ **# OF PREGNANCIES:** _____ **# OF CHILDREN:** ____

DATE OF LAST PAP SMEAR: _____ **DATE OF LAST MAMMOGRAM:** _____

SIGNIFICANT GYNECOLOGICAL HISTORY: _____

_____

_____

IF MALE:

DATE OF LAST PROSTATE EXAMINATION: ____/____/_____

SIGNIFICANT GENITOURINARY HISTORY: _____

_____

_____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

J acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of :Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

NAME (PRINT): _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

NOTES