

LIV Medical Weight Loss & Aesthetics/ Patient History						Office Use Only	
<i>All questions contained in this history form are strictly confidential and will become part of your medical record on file.</i>							
Last Name:	First Name:	Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: / /	Age:		Chart:
Primary Physician/Referral:			Physician Phone Number: ()				Date:
Optometrist/Ophthalmologist:			Ophthalmologist Phone Number: ()			Revisions:	
Last Physical:		Last EKG:	Last Eye Exam:			Weight:	
						Goal Weight:	

Health History Complete to the best of your knowledge.

	Family	Personal		Family	Personal		Family	Personal
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Other:

Surgeries & Other Hospitalizations

Year	Reason / Diagnosis	Hospital

Medication Allergies

Medication Name	Reaction

Prescribed Medications & Over-the-Counter drugs, dietary supplements (including vitamins, inhalers, etc)			
Medication Name	Strength	Frequency	
Behavior Style			<i>Please select only one answer.</i>
<input type="checkbox"/>	You are always calm and easygoing.	<input type="checkbox"/>	You are usually calm and easygoing.
<input type="checkbox"/>	You are seldom calm and persistently driving for advancement	<input type="checkbox"/>	You are never calm and have overwhelming ambition
<input type="checkbox"/>		<input type="checkbox"/>	You are sometimes calm and easygoing
<input type="checkbox"/>		<input type="checkbox"/>	You are hard-driving and never relax.
Health Habits & Personal Safety			<i>This section is optional. All answers will be kept strictly confidential.</i>
Exercise	<input type="checkbox"/> Sedentary (no exercise)		
	<input type="checkbox"/> Mild Exercise (i.e., climbing stairs, walking three blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician-prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many meals do you eat in an average day?		
	Rank your salt intake:		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank your fat intake:		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Caffeine	Rank your caffeine intake:		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None
	What types of caffeine do you drink?		<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda
	How many cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		<input type="checkbox"/> Beer <input type="checkbox"/> Liquor <input type="checkbox"/> Wine
	How many drinks per week?		
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs/day:	<input type="checkbox"/> Chew – #/day:	<input type="checkbox"/> Pipe – #/day: <input type="checkbox"/> Cigars – #/day:
	How many years?		
	If you previously used tobacco, what year did you quit?		
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever taken street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If you are not trying for a pregnancy, what contraceptive methods are you using?		
Women Only			
How old were you at onset of menstruation?		Date of last menstruation?	
How often do you get your period (days)?		Number of Pregnancies:	Number of live births:
Heavy periods, irregularity, spotting, pain, or discharge?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant, trying for pregnancy, or breast feeding?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Weight History

1. What is the main reason you decided to lose weight?
2. When did you begin gaining excess weight (give reasons if known)?
3. What do you think is the main cause of your weight problems?
4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5. Is your spouse, fiancé, or partner overweight?
6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
7. List any food allergies:
8. What foods do you avoid?
9. What foods do you crave?
10. Do you awaken hungry during the night?
11. What are your worst food habits?
12. What are your snack habits?
13. Rate your body from 1 to 10. How would you describe your body?
14. If you could change one thing about your body, what would it be?
15. What do you feel will be your obstacle(s) to successful weight loss?
16. What is your typical breakfast? What time? Where? With whom?
17. What is your typical lunch? What time? Where? With whom?
18. What is your typical dinner? What time? Where? With whom?
19. Add any additional comments you think would be helpful to the doctor.

Accuracy Agreement

I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.

Signature:

Date:

Thank You.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.

LIV Medical Weight Loss & Aesthetics/ HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physicians practice, and any other use required by law.

Treatment

We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used as needed to obtain payment for your health care services.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you be name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses and Disclosures

Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Individual Rights:

- 1. You have the right to inspect and receive a copy of your protected health information.** Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
- 2. You have the right to request a restriction on the disclosure of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of our protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.
- 3. You have the right to request to receive confidential communications from us by an alternative means or at an alternative location.**
- 4. You have the right to obtain a paper copy of this notice from us.**
- 5. You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

Complaints

You may file any complaints with our Privacy Officer, William Horninger, at (954) 525-4273, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

LIV Medical Weight Loss & Aesthetics /Receipt of Notice of Privacy Practices		Chart:
LIV Medical Weight Loss & Aesthetics reserves the right to modify the privacy practices outlined in this notice.		
By signing below, I am indicating that I have received a copy of the Notice of Privacy practices for LIV Medical Weight Loss & Aesthetics		
Printed Name:	Patient Signature:	Date: