SPENCER KROLL MD PhD WEISSMAN AND KROLL MEDICAL ASSOCIATES (732)591-8840 FAX (732) 591-2822

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No
When was your last complete Physical Exam?		
When was your last chest X-ray		
When was your last colonoscopy		
When was your last eye exam?		
When was your last bone density test?		
When was your last blood work?		
When was your last PSA test?		

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers PLEASE BRING ALL CURRENT MEDICINE BOTTLES TO YOUR FIRST APPOINTMENT		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

PLEASE SPECIFY FAMILY MEMBERS WITH HEART DISEASE, STROKE, DIABETES, CANCER, KIDNEY DISEASE, ALZHEIMERS, ALCOHOLISM, ANEMIA, DEPRESSION, HIGH BLOOD PRESSURE, BLEEDING DISORDER

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor/psychologist/psychiastrist?	☐ Yes	☐ No

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WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please describe:

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Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

The Kroll Medical Group

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____

Alternate Phone Number: Cell ☐ Work ☐ _____

E-Mail Address: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M ☐ F ☐ SS# _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Patient's Employer: _____

Employment Status: Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student ☐ Other ☐

Emergency Contact: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____

INSURANCE INFORMATION (We will request to scan your ID and insurance card.)

Primary Insurance: _____ Patient is Subscriber/Policy Holder: Y ☐ N ☐

Secondary Insurance: _____ Patient is Subscriber/Policy Holder: Y ☐ N ☐

Co-Pay _____

Group Number: _____

ID Number: _____

Cancellation Fees: *The Kroll Medical Group reserves the right to charge a fee for any scheduled visits that are cancelled with less than 24 hours notice or missed without calling to cancel (no show).*
Fee Schedule: New Patient or physical $50.00; Established Patient: $25.00

Patient/Parent or Guardian Signature: _____ Date: _____

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If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Submit Reset Print

The Kroll Medical Group

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all individual, group, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to The Kroll Medical Group and each of the physicians for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to The Kroll Medical Group for services rendered to me during the applicable periods of medical care.
2. **Unauthorized, Non-Covered, or Out-of-Plan Services** – In some cases, your physician may order specific tests or specific studies to either detect disease or as part of a process to determine what the diagnosis may be. In some cases, Medicare and other insurance companies will only pay for services that they consider "reasonable and necessary." I understand my Insurance Plan(s) may not consider a service rendered as a covered service or has not authorized this service, and they may not pay for this service. I agree to be fully responsible for payment to The Kroll Medical Group for this service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out-of-Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me. I acknowledge I will be responsible for any remaining balance.
3. **For Medicare Recipients Only** – I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to The Kroll Medical Group and/or independent contractors for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

Patient Signature: _____ Date: _____

I certify that I have been made aware of **The Kroll Medical Group's Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of The Kroll Medical Group's health care operations. The Notice also describes my rights and The Kroll Medical Group's duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration area and on The Kroll Medical Group's website at www.NJLIPID.com. I may request that a copy be mailed to me by calling 732-591-8840.

Patient Signature: _____ Date: _____