



Eastern Long Island Family Medicine, P.C.

Christopher Ng, M.D.

Diplomate of the American Board of Family Medicine

Assistant Professor, SUNY Stony Brook, Department of Family Medicine

100 South Jersey Ave . Suite 14 . Setauket, New York 11733 . (631)751-3883 . Fax (631)751-3909

Medical History

NAME _____ DATE _____ AGENCY _____

BADGE NUMBER _____ DOB _____ AGE _____ GENDER _____ NEW MEMBER _____

ADDRESS _____ TOWN _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PERSONAL PHYSICIAN _____ NOT APPLICABLE

OCCUPATION _____ EMAIL ADDRESS _____

Allergy **Check if none**

Type of Reaction

Past Medical History

Please check any conditions you have had in the past or are currently experiencing: **Check if none**

High Blood Pressure	Bronchitis	Change in bowel habits	Arthritis
Diabetes	Pneumonia	Unexplained weight	Low back problems
Cancer	Persistent cough	gain/loss?	Skin diseases
Heart disease	T.B.	Hemorrhoids	Blood disorder
Chest pain/tightness	Hay fever	Gall Bladder disease	Venereal disease
Shortness of breath	Abdominal pain	Colitis	Anxiety
Swollen ankles	Indigestion	Hepatitis or jaundice	Depression
Palpitations	Nausea	Thyroid disease	Anemia
Lightheadedness	Vomiting	Alcohol abuse	Frequent Urination
Constipation	Headache	Drug abuse	Rheumatic fever
Diarrhea	Seizures	Asthma	Blood in stool
Kidney stones	Gout	Ulcers	Difficulty urinating
Impotence/erectile dysfunction	Insomnia	Kidney Problems	Heart Problems
Lung Problems	Vision Problems	Wear contacts/glasses	Hearing problems
Wear Hearing Aid	Smoke/ use tobacco products		High cholesterol



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Have you ever had an injury or illness which caused loss or permanent impairment of a "paired organ)?
(arms, legs, ears, eyes, ovaries, testis, kidneys, or lungs)

Do any of your "blood" relatives have high blood pressure, diabetes, cancer, or heart disease?

Have you ever worked with chemicals, asbestos, or other hazardous materials?

Please list any other problems, or explanations for any that were checked from above:

Female members **If male, skip this section**

Are your menstrual periods regular?

Have your pap tests and mammograms always been normal?

What was the date of your last pap test? _____

Check box for N/A

What was the date of your last menstrual period? _____

Check box for N/A

What was the date of your last mammogram? _____

Check box for N/A

HAVE YOU HAD ANY HOSPITALIZATIONS OR BEEN TAKEN OUT OF SERVICE SINCE YOUR LAST VISIT HERE?

If yes, please explain _____



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Female members

PAST SURGERIES

Type of surgery	Check if none	Date of surgery
_____		_____
_____		_____
_____		_____
_____		_____

Medication List (list all supplements, OTC drugs, vitamins, and prescription medication)

Name of medication	Check if none	Dosage and Frequency
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Other Physicians Treating You (for example: GYN, Cardiologist, Eye Doctor, etc.)

Name and Specialty	Check if none	Reason For Treatment	Providers Phone#
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

Preventative medicine

Please check any immunizations you have had, and date administered:

Hepatitis B: _____ Date: _____ Flu immunization: _____ Date: _____

Tetanus immunization: _____ Date: _____ Pneumovax: _____ Date: _____

Pprevnar: _____ Date: _____ PPD: _____ Date: _____



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AHA/ACSM Health/Fitness Facility Preparticipation Screening Questionnaire

Assess your health status by marking all *true* statements

History

You have had:

- ☐ a heart attack
- ☐ heart surgery
- ☐ cardiac catheterization
- ☐ coronary angioplasty (PTCA)
- ☐ pacemaker/implantable cardiac
- ☐ defibrillator/rhythm disturbance
- ☐ heart valve disease
- ☐ heart failure
- ☐ heart transplantation
- ☐ congenital heart disease

Symptoms

- ☐ You experience chest discomfort with exertion.
- ☐ You experience unreasonable breathlessness.
- ☐ You experience dizziness, fainting, or blackouts.
- ☐ You take heart medications.

Other health issues

- ☐ You have diabetes.
- ☐ You have asthma or other lung disease.
- ☐ You have burning or cramping sensation in your lower legs when walking short distances.
- ☐ You have musculoskeletal problems that limit your physical activity.
- ☐ You have concerns about the safety of exercise.
- ☐ You take prescription medication(s).
- ☐ You are pregnant

If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a **medically qualified staff**.



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Cardiovascular risk factors

- ☐ You are a man older than 45 years.
- ☐ You are a woman older than 55 years, have had a hysterectomy or are postmenopausal.
- ☐ You smoke or quit smoking within the previous 6 months.
- ☐ Your blood pressure is >140/90 mm Hg.
- ☐ You do not know your blood pressure.
- ☐ You take blood pressure medication.
- ☐ Your blood cholesterol level is > 200 mg/dL.
- ☐ You do not know your cholesterol level.
- ☐ You have a close blood relative who had a heart attack guide your exercise program or heart surgery before age 55 (father or brother) or age 65 (mother or sister).
- ☐ You are > 20 pounds overweight.
- ☐ You are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days per week).

If you marked two or more of the statements in this section, you should consult your physician or other appropriate health care provider before engaging in exercise. You might benefit from using a facility with a professionally qualified exercise staff to guide your exercise program.

-
- ☐ None of the above You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self- guided program or almost any facility that meets your exercise program needs

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

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9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____ Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize Dr. Christopher Ng
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- ☐ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.