HEALTH HISTORY QUESTIONNAIRE

SIU Medicine – Carbondale

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

SIU Medicine – Carbondale
305 West Jackson Street,
Suite 200
Carbondale, IL 62901

Phone: (618) 536-6621
Fax: (618) 453-1102

Name *(Last, First, M.I.):*	☐ Male ☐ Other ☐ Female	**DOB:**
Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed		
Occupation:	**Religious Preference:**	
Previous doctor:	**Date of last physical exam:**	
Preferred Pharmacy:		

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

Specialists you are currently seeing:

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Recent Procedures/Testing	**Dates**
Colonoscopy	
Pap Smear	
Mammogram	
Bone Density	

Allergies to medications:

List any metal in your body:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug	Strength	Frequency Taken

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	☐ High	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
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

FAMILY HEALTH HISTORY

	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*		

SIU MEDICINE
FORWARD. FOR YOU.

SIU Medical Record #_____

AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION TO PERSONS INVOLVED IN MY CARE

Patient Name _____ Date of Birth:_____
PLEASE PRINT Daytime Phone:_____
Address:_____ City:_____State:_____

I hereby give SIU HealthCare my permission to release my medical information to the individual(s) specified below, upon their request. Methods of release may include verbal discussions or updates about my medical treatment, medications, or condition as requested. The purpose for these disclosures is to enable the person/s below to assist me in maintaining my health, and to participate in my medical care.

_____	_____	_____
Name	Relationship to Patient	Date

The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse and infectious diseases, including HIV, and medical correspondence. Please check and initial the box for which you will authorize disclosure of information; and sign below.

- ❑ _____Mental Health
- ❑ _____Developmental Disability
- ❑ _____Alcohol or Drug Abuse
- ❑ _____Infectious Diseases Including HIV
- ❑ _____Genetic Testing
- ❑ _____Other

I understand that I may revoke this authorization at any time by notifying SIU HealthCare in writing, but the revocation will not affect any actions which they have taken prior to the receipt of the revocation. I understand that this authorization will continue until I revoke it. SIU HealthCare may request a new authorization form be completed periodically.

I understand this authorization must be filled out completely, signed and dated in order to be processed.

I hereby authorize the use or disclosure of my individually identifiable medical information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization authorized to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure.

FORM MUST BE COMPLETED BEFORE SIGNING

_____	_____	_____
(Signature of Patient or Patient's Legal Representative)	Date of Birth	Date

_____	_____
(Signature of Witness)	Date

Printed Name of Patient's Representative:_____
Relationship to Patient:_____

This form should be scanned into the patient's EHR record as well as the authorized person's name entered into the Centricity Business (CB) banner to alert appropriate staff of authorization.

Revised 8/09; 1/10; 12/14
(HIPAA Policy: 1.200 Auth Verbal Release)
Revised & Approved by Legal and Breach Committee: 1 /2015
Approved by Quality & Safety Committee: 2/17/15

(Facsimile reproductions of the signatures are acceptable)

SIU MEDICINE
FORWARD. FOR YOU.

SIU Medicine-Carbondale
305 West Jackson Street, Suite 200
Carbondale, IL 62901
Phone: (618) 536-6621
Fax: (618) 453-1102

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO SIU MEDICINE

Patient Name_____ Health Record Number_____

Date of Birth_____ Telephone (__)_____

_____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure to SIU:_____

_____

3. Please send the requested documents to SIU (Address) _____ _

_____

Attn: (Physician)_____ Fax: (217)_____ Phone: (217)_____

4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ problem list
- ❑ list of allergies
- ❑ most recent history and physical
- ❑ laboratory results
- ❑ x-ray and imaging reports
- ❑ consultation reports
- ❑ entire record
- ❑ medication list
- ❑ immunization record
- ❑ Doctor/Specialty records only

From (date) _____to (date) _____
from (date)_____ to (date)_____
from (doctor's names) _____
from (date)_____ to (date)_____

Other — specify dates of service or other materials to be released: _____

_____

4. I authorize the release of sensitive information as indicated:

The patient 12 or over who consented to the treatment must authorize the release of sensitive information.

- ❑ AIDS / HIV
- ❑ Drug / Alcohol Abuse
- ❑ Behavioral Health
- ❑ Genetic Information
- ❑ Sexual Assault
- ❑ Child Abuse
- ❑ Developmental Disabilities

5. Special Instructions: (e.g. appointment date or pick-up date/time/location)_____

_____

6. I understand the following provisions:

- I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits.
- I understand that I have the right to revoke this authorization at any time, in writing, and must deliver the revocation to the individual or organization providing the information.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- Any disclosure of information has the potential for an unauthorized re-disclosure by the recipient and as such would no longer be protected by law**.
- If not otherwise specified, this authorization will expire in six months after it is signed.
- I may inspect or copy the information to be used or disclosed as provided by law.

Signature of Patient or Consenting Individual _____Date _____

If signature is not of Patient, indicate relationship_____Date _____

Signature of Witness _____Title_____ Date_____

**NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: You may not re-disclose any records disclosed to you pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act (720 ILCS 110/ et seq.) or the federal Alcohol Drug Treatment regulations, (42 CFR 2 et seq.) unless the person who consented to this disclosure specifically consents to such re-disclosure.

***Documents received need to be scanned in EHR after Provider review**

Revised 1/15,Q&S 9/1/16 Legal