Medical History

Full Name

First Name

Last Name

What is your Gender?

- [ ] Male
- [ ] Female

Check the conditions that apply to you or to any members of your immediate relatives:

- [ ] Asthma
- [ ] Cancer
- [ ] Cardiac disease
- [ ] Diabetes
- [ ] Hypertension
- [ ] Psychiatric disorder
- [ ] Epilepsy

Check the symptoms that you have experienced in the PAST 6 WEEKS

- ☐ Fever/Chills
- ☐ Unexplained change in weight
- ☐ Fatigue/Malaise/Generalized weakness
- ☐ Headaches/Migraines
- ☐ Dizziness
- ☐ Sinus Pain/Pressure/Discharge
- ☐ Excessive snoring
- ☐ Wheezing/Chronic Cough
- ☐ Shortness of breath
- ☐ Chest pain, pressure or tightness
- ☐ Swelling of hands/feet/ankles
- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Constipation or diarrhea
- ☐ Stiffness/Pain in joints/muscles
- ☐ Joint swelling
- ☐ Bleeding/Easy bruising
- ☐ Excessive urination
- ☐ Excessive thirst/hunger
- ☐ Hot flashes
- ☐ Painful/Bloody urination
- ☐ Difficulty urinating/Night-time urination
- ☐ Urinary incontinence (leakage)
- ☐ Sexual Difficulties/Painful intercourse
- ☐ Rash
- ☐ Anxiety/Panic Attacks
- ☐ Concentration Difficulty
- ☐ Feelings of Guilt
- ☐ Insomnia/Problems with Sleep
- ☐ Loss of energy
- ☐ Thoughts of harming self or others

For women only: Date of last menstrual period Month Day Year

For women only: Number of pregnancies

Number of live births

Are you taking any hormones or birth control? ☐ Yes ☐ No

Do you have irregular or painful periods? ☐ Yes ☐ No

Are you currently taking any medication?

☐ Yes

☐ No

If so, please list:

Do you have any medication allergies?

☐ Yes

☐ No

☐ Not Sure

Do you use or do you have history of using tobacco?

-

Do you use or do you have history of using illegal drugs?

-

How often do you consume alcohol?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Occasionally
- ☐ Never

JCertain Waivers under HIPAA.

(a) Patient acknowledges that PharmAssist, PLLC guarantees that communications with Physician using electronic mail ("e-mail"), facsimile, video chat, instant messaging, and cellular telephone are secure or confidential methods of communications. Accordingly, Patient expressly waives PharmAssist's obligations under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, and all rules and regulations promulgated thereunder (collectively, "HIPAA"), and other state and federal laws and regulations applicable to the use, maintenance, and disclosure of patient-related information, to guarantee confidentiality with respect to correspondence using such means of communication. Patient acknowledges that all such communications may become a part of Patient's medical records maintained by PharmAssist, PLLC.

(b) By providing Patient's e-mail address to PharmAssist, PLLC -Patient authorizes PharmAssist to communicate with Patient by e-mail regarding Patient's "protected health information" ("PHI") (as defined under HIPAA) and Patient understands and agrees to the following:

1. E-mail is not necessarily a secure medium for sending or receiving PHI and, accordingly, any third party may gain access to such PHI;
2. Although PharmAssist, PLLC will make all reasonable efforts to keep e-mail communications confidential and secure, PharmAssist, PLLC cannot assure or guarantee the absolute confidentiality of such e-mail communications.

Patient Initials:

Patient acknowledges and agrees that PharmAssist, PLLC, along with their assigns, will be entitled to use any data, discoveries, results, improvements or other information resulting from the Services for any lawful purpose whatsoever, including, but not limited to, internal research, academic or other publications or commercial purposes. All data will be kept on a Cloud Based system that is password protected, and accessible to PharmAssist, PLLC staff.

Patient Name

Today's Date

Month Day Year

Patient Date of Birth

Month Day Year

I,

First Name Last Name

give my express permission to PharmAssist, PLLC and Halle Harrison, Pharm.D., to obtain and access to all of my medical records. I understand that my personal and medical information may be stored on a password protected secure cloud service.

Patient Name

Today's Date

Month Day Year

Patient Date of Birth

Month Day Year

Any exceptions to medical record access:

Submit