Health Questionnaire

To be completed by the patient - *Please Print*

Name _____ Today's Date _____

Date of Birth _____ / _____ / _____ Age _____ Height _____ Weight _____

Have you recently gained or lost weight? Y N How much _____

Drug Allergies _____

Chief Complaints: (Please list in order of importance the present health concerns, symptoms, or problems you are experiencing) _____

_____

_____

Hospitalizations: (If you have been in the hospital overnight, state the year, illness, operation. Do not include normal pregnancies.)

Year	Illness/Operation	Year	Illness/Operation

Past Medical History: Have you ever had the following (circle yes or no, leave blank if uncertain)

AIDS or HIV+	Y N							
Anemia	Y N	Heart Burn	Y N	Pneumonia	Y N
Arthritis	Y N	Heart Murmur	Y N	Psoriasis	Y N
Asthma	Y N	Hemorrhoids	Y N	Polio	Y N
Back Trouble	Y N	Hepatitis	Y N	Rheumatic Fever	Y N
Bladder Infection	Y N	Hernia	Y N	Scarlet Fever	Y N
Blood in Urine	Y N	High or Low B/P	Y N	Shingles	Y N
Bleeding Tendency	Y N	Hives or Eczema	Y N	Smallpox	Y N
Bronchitis	Y N	Infection Mono	Y N	Stomach Ulcer	Y N
Cancer	Y N	Kidney Disease	Y N	Stroke	Y N
Cataracts	Y N	Measles	Y N	Sun Sensitivity	Y N
Diabetes	Y N	Migraines	Y N	Tattoos	Y N
Dry Eyes	Y N	Mitral Valve	Y N	Tuberculosis	Y N
Dry Mouth	Y N	Mumps	Y N	Transfusions	Y N
Epilepsy	Y N	Mouth Sores	Y N	Veneral Disease	Y N
Glaucoma	Y N	Nose Sores	Y N	Whooping Cough	Y N
Gout	Y N	Raynaud's	Y N	Any Other Diseases	Y N
Hair Loss	Y N	Pink Eye	Y N		
Heart Disease	Y N	Pleurisy	Y N		

Comments: (If you circled yes to any other diseases please list in this space.)

_____

_____

Family History

Has any blood relative had any of the following: (Circle yes or no, leave blank if uncertain.)

			Relationship				Relationship
Allergies	Y	N	_____	Diabetes	Y	N	_____
Arthritis	Y	N	_____	Double Jointed	Y	N	_____
Osteoarthritis	Y	N	_____	Epilepsy	Y	N	_____
Rheumatoid	Y	N	_____	Heart Disease	Y	N	_____
Gout	Y	N	_____	High Blood Pressure	Y	N	_____
Bleeding Tendency	Y	N	_____	Osteoporosis	Y	N	_____
				Stroke	Y	N	_____

Medications (Now on) Dosage Times/Day

_____

_____

_____

_____

_____

_____

Social History

Have you ever or do you now:

Tobacco Y N Packs per day_____ for _____ years

Alcohol Y N Drinks per week _____

Caffeine Y N Cups per day _____

The Last Time you had a (list year)

Colonoscopy	_____	Tetanus shot	_____
Hepatitis Vac	_____	TB Test	_____
Pneumonia Shot	_____	Rectal Exam	_____
Stool BLD test	_____	Eye Exam	_____
Sigmoid exam	_____	PSA	_____
Cholesterol Test	_____	Prostate Exam	_____
Mammogram	_____	*Bone Density	_____

**Circle Type of Bone Density:*
Wrist Finger Hip Spine/Hip Heel

For Women Only

Age at onset of menstrual period _____

Date of onset of Menopause _____ Natural: Y N Age: _____

Have you had a Hysterectomy? Y N Date of Surgery: _____

Have you been treated with Hormone Replacement Treatment Y N

Are you currently under the care of a physician for another medical condition? Y N

Condition: _____ Physician: _____

How long have you had your current symptoms related to today's appointment? _____

Have you seen another physician for this problem? Y N

What kind of treatment was prescribed:

Please circle all that apply

Surgery Injections X-Rays Physical Therapy Medications Hospitalization CAT Scan Bone Scan

MEDICARE/THIRD PARTY PAYER RELEASE*

*Third Party includes all other insurance providers

I authorize any holder of medical or other information about me to release to my contracted health insurance carrier or the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information. Regulations pertaining to Medicare assignment of benefits also apply.;

Signature____ Date_________________

MEDIGAP AUTHORIZATION

I authorize any holder of medical or other information about me to release to my supplemental insurance carrier any needed information on this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature ____ Date_________________

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RELEASE OF MEDICAL INFORMATION

In accordance with the new HIPPA regulations and as a means of protecting the privacy of your medical record, we are asking your consent to release and disclose your medical records to your primary care physician or other specifically designated health care participants in your care. Please list your current providers with whom we may release medical information if requested.

In addition, I am consenting to have David R. Mandel, M.D., Inc. release and disclose my medical record information to the following family member(s)/caretaker(s) or other person(s):

Provider Name: ____

Name: ____

Signature ____ Date________________

•••

I, ____, have received/reviewed a copy of DAVID R. MANDEL, M.D., INC.'S Notice of Privacy Practices.

Signature ____ Date ________________

RAPID5 Multidimensional Health Assessment Questionnaire (MDHAQ)

YOUR NAME:_____ **Date of Birth:** _____ **Today's Date:**_____

1. Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces, doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN OOOOOOOOOOOOOOOOOOOO **PAIN AS BAD AS IT COULD BE**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
LEFT FINGERS	☐0	☐1	☐2	☐3	RIGHT FINGERS	☐0	☐1	☐2	☐3
LEFT WRIST	☐0	☐1	☐2	☐3	RIGHT WRIST	☐0	☐1	☐2	☐3
LEFT ELBOW	☐0	☐1	☐2	☐3	RIGHT ELBOW	☐0	☐1	☐2	☐3
LEFT SHOULDER	☐0	☐1	☐2	☐3	RIGHT SHOULDER	☐0	☐1	☐2	☐3
LEFT HIP	☐0	☐1	☐2	☐3	RIGHT HIP	☐0	☐1	☐2	☐3
LEFT KNEE	☐0	☐1	☐2	☐3	RIGHT KNEE	☐0	☐1	☐2	☐3
LEFT ANKLE	☐0	☐1	☐2	☐3	RIGHT ANKLE	☐0	☐1	☐2	☐3
LEFT TOES	☐0	☐1	☐2	☐3	RIGHT TOES	☐0	☐1	☐2	☐3
NECK	☐0	☐1	☐2	☐3	BACK	☐0	☐1	☐2	☐3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL OOOOOOOOOOOOOOOOOOOO **VERY POORLY**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

DO NOT WRITE BELOW THIS – FOR DOCTOR'S USE ONLY – MD Global

VERY WELL OOOOOOOOOOOOOOOOOOOO VERY POORLY

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

FN 0-10 ☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

PN 0-10 ☐

PTGL 0-10 ☐

RAPID3 0-30 ☐

JT CT 0-10 ☐

1=0.2 25=5.2
2=0.4 26=5.4
3=0.6 27=5.6
4=0.8 28=5.8
5=1.0 29=6.0
6=1.3 30=6.3
7=1.5 31=6.4
8=1.7 32=6.7
9=1.9 33=6.9
10=2.1 34=7.1
11=2.3 35=7.3
12=2.5 36=7.5
13=2.7 37=7.7
14=2.9 38=7.9
15=3.1 39=8.1
16=3.3 40=8.3
17=3.5 41=8.5
18=3.8 42=8.8
19=4.0 43=9.0
20=4.2 44=9.2
21=4.4 45=9.4
22=4.6 46=9.6
23=4.8 47=9.8
24=5.0 48=10

RAPID4 0-40 ☐

MDGL:0-10 ☐

RAPID5 0-50 ☐