Institute of Integrative and Age-Management Medicine (IAAM)
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HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

Please complete the following comprehensive personal data form thoroughly. Completion of this form will take time, but the more detailed information we have about you, the better we can customize your treatment.

Today's Date: ______________________________

PART I. PERSONAL INFORMATION

Last Name | First Name | Middle Initial

Age | Birth Date | Height | Weight | Social Security Number

Home Address | City | State | Zip

Home Telephone | Cell Phone | Home Fax No. | Email Address

Employer | Work Telephone | Work Fax No.

Emergency Contact Person | Relationship | Telephone

PCP | Phone | Fax

Address | City | State | Zip

Pharmacy | Phone | Fax

Sex: [ ] Male [ ] Female

[ ] Married [ ] Divorced [ ] Single

[ ] African American [ ] Caucasian [ ] Asian [ ] American Indian/Alaskan Native [ ] Hispanic [ ] Pacific Islander [ ] Other: _________________________

Referred By: ____

Patient Name: ___________________________________

PART II. MEDICATIONS & IMMUNIZATIONS

Which of the following do you take more than once a week?

[ ] None
[ ] Acetaminophen
[ ] Antacids
[ ] Antihistamines/Allergy Pills
[ ] Arthritis medication
[ ] Aspirin
[ ] Birth Control Pills
[ ] Blood Pressure Pills
[ ] Decongestants/Cold Pills
[ ] Heart Medication
[ ] Hormones
[ ] Ibuprofen (Advil/Motrin)
[ ] Insulin, Diabetic Pills
[ ] Laxatives
[ ] Stomach/Intestinal Pills
[ ] Thyroid Medication
[ ] Tranquilizers/Sedatives
[ ] Vitamins
[ ] Weight Reduction Pills

List any other medications (prescription, non-prescription, herbal & vitamins) you currently take:

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Current or previous use of Hormonal Therapy:
[ ] Growth Hormone [ ] Testosterone [ ] Progesterone [ ] DHEA
[ ] Estrogen – (type) ______________________________

Have you received the Hepatitis B Vaccine? [ ] Yes [ ] No
If "yes", number of shots [ ] 1 [ ] 2 [ ] 3 Year completed ____________
Year of last tetanus booster:___________
If born after 1956, date of last Measles booster: __________
Have you ever received (or are current) a Flu shot? _________
Have you ever received (or are current) a Pneumovax? _________
Other Immunizations:____

Additional Comments:

Patient Name: ____________________________________

PART III. ALLERGIES

[ ] None
[ ] Drugs
Specify____
[ ] Dusts or Molds
Specify____
[ ] Pollens
Specify____
[ ] Animal
Specify____
[ ] Food
Specify____
[ ] Other
Specify____

Additional Comments:

Patient Name: ___________________________________

PART IV. SOCIAL HISTORY

Have you ever used tobacco? [ ] Yes [ ] No
If "yes" When__________ [ ] Current [ ] Past Years since quitting_________
Type: [ ] Cigarettes [ ] Pipe [ ] Cigar [ ] Snuff/Chewing
How many per day? ________________ For how many years? _____________

What is your average alcohol consumption per week? _______________ drinks

Have you ever used recreational drugs? [ ] Yes [ ] No

What sports, recreational, or exercise activities do you participate in?
____
____
____

Additional Comments:

Patient Name: ___________________________________

PART V. MEDICAL HISTORY

Which of the following conditions have you ever had?
Enter year of diagnosis, or place check if unknown

[ ] Head Injury
[ ] Migraines
[ ] Seizures
[ ] Stroke
[ ] Glaucoma
[ ] Cataracts
[ ] Thyroid Trouble
[ ] Diabetes
[ ] High Blood Pressure
[ ] Heart Murmur
[ ] Rheumatic Fever
[ ] Heart Attack
[ ] Pneumonia
[ ] Asthma
[ ] Emphysema
[ ] Motor Vehicle Accidents or severe injuries
[ ] Positive skin test for TB
[ ] Active Tuberculosis
[ ] Ulcers
[ ] Hepatitis
[ ] Gallstones
[ ] Bladder Infections
[ ] Kidney Stones
[ ] Arthritis
[ ] Gout
[ ] Herniated Disc
[ ] Sexually Transmitted Disease
[ ] Anemia
[ ] Tumors
[ ] Cancer
[ ] Depression/Anxiety

Specify____
____

Other medical/psychiatric disorders. Specify.
____
____
____

Additional Comments:

Patient Name: ___________________________________

PART VI. HOSPITALIZATIONS AND SURGERIES

Year Reason

____

____

____

____

____

____

____

Additional Comments:

Patient Name: ___________________________________

PART VII. FAMILY HISTORY

	Yes	No	Age	Year Deceased	Cause of Death
Is your mother living?	[ ]	[ ]	____	_______	________
Is your father living?	[ ]	[ ]	____	_______	________
Are your brothers/sisters living?	[ ]	[ ]	____	_______	________

Which of the following have your parents, brothers, sisters or children ever had?

[ ] Thyroid disease
[ ] Heart trouble or disease
[ ] Cancer or leukemia
[ ] Diabetes
[ ] High Blood Pressure
[ ] Kidney Trouble
[ ] High Cholesterol
[ ] Alzheimer's Disease
[ ] Depression/suicide
[ ] Other psychiatric diseases
[ ] Alcoholism
[ ] Tuberculosis
[ ] Asthma
[ ] Genetic Diseases
[ ] Stroke

Additional Comments:

Patient Name: ___________________________________

PART VIII. OCCUPATIONAL HISTORY

Briefly describe the activities of your current job: ________________________________
____

How long have you been doing this type of work? ______ years
Have you ever been off the job more than a day because of work related illness or injury?
[ ] Yes [ ] No
Specify____
____

List any occupational exposures you have had (e.g. noise, chemicals, etc.)
____

What level of stress is associated with your occupation or your life?
____

How do you handle this stress?
____

Additional Comments:

Patient Name: ___________________________________

PART IX. REVIEW OF SYSTEMS

Which of the following have been a problem for you?

General/Constitutional
[ ] Fever >101 ˚ F
[ ] Night sweats
[ ] Shivering chills
[ ] Generalized weakness
[ ] Unexplained weight loss/gain
[ ] Excessive fatigue
[ ] Swollen glands
[ ] Loss of appetite

Genitourinary/Reproductive
[ ] Difficult or painful urination
[ ] Blood in urine
[ ] Loss of bladder control
[ ] Diarrhea
[ ] Frequent urination
[ ] Difficulty in having children

(MEN ONLY)
[ ] Prostate trouble
[ ] Testicular disorder
[ ] Penile discharge
[ ] Impotence

(WOMEN ONLY)
[ ] Irregular periods/spotting
[ ] Vaginal discharge
[ ] Miscarriage or stillborn pregnancy
[ ] Breast lump/discharge
[ ] D.E.S. exposure
[ ] Currently or possibly pregnant
Last Pap Smear _______
Last Period _______

Heart
[ ] Chest pain or pressure
[ ] Irregular heart beat
[ ] Palpitations/skipped beats

Lungs
[ ] Shortness of breath
[ ] Coughing up blood
[ ] Wheezing
[ ] New or change in cough

Digestive System
[ ] Nausea/vomiting
[ ] Constipation
[ ] Yellow jaundice
[ ] Rectal bleeding
[ ] Black/tarry stools
[ ] Hemorrhoids

Neurological/Psychiatric
[ ] Headaches
[ ] Dizziness
[ ] Passing out/fainting
[ ] Numbness or tingling
[ ] Loss of memory
[ ] Excessive anxiety
[ ] Insomnia/difficulty sleeping

[ ] Excessive sadness

Skin/Musculoskeletal
[ ] Back pain
[ ] Neck pain
[ ] Joint pain
[ ] Moles-changing
[ ] Rashes
[ ] Weakness in arm/leg

Eyes
[ ] Change in vision
[ ] Itching
[ ] Tearing

Ears, Nose, Throat
[ ] Earaches
[ ] Difficulty hearing
[ ] Ringing, buzzing
[ ] Sinus trouble
[ ] Difficulty Swallowing
[ ] Sneezing/runny nose
[ ] Nosebleeds
[ ] Mouth sores
[ ] Hoarseness
[ ] Congestion

Patient Name: ___________________________________

Rank each category (circle one) 1= poor, 3= average, 5= excellent

Energy level	1	2	3	4	5
Libido	1	2	3	4	5
Cognition/Memory	1	2	3	4	5
Fitness	1	2	3	4	5
Sleep	1	2	3	4	5
Stress	1	2	3	4	5

Additional Comments:

NOTICE OF HIPAA/PRIVACY PRACTICES

TO OUR PATIENTS:
This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or the organization able to help or prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials. If you are an inmate or under the custody of law enforcement officials.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals in your care of the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that my be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.
   To file a complaint with our office contact:
   Office Manager
   3703 Taylorsville Road
   Suite 120
   Louisville, KY 40220
   All Complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other use and disclosures that are not identified by this notice or permitted by applicable law.

By signing below, I have read and understood the above document and have been given a copy.

Patient Signature: ______________________________ **Date:** ________________

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I, ____, have read and understand all materials related to the treatment requested from Peggy H. Fishman, MD & the Center for Integrative and Age-Management Medicine. Responses and answers to written and spoken questions have been answered truthfully and to the best of my ability. Ample and plentiful time was allotted to answer all questions, inquiries, and explanations regarding treatment to make an informed and intelligent decision. Risks, benefits, alternatives and complications from said treatment have been completely and thoroughly explained.

Fees and payment policies have been discussed completely in their entirety. I understand payment is due at the time that services are rendered. Any and all questions regarding fees and payment policy have been answered fully by the clinic. ***NOTE: All baseline Plan I or II lab testing is billed to our account. We do not recommend billing insurance as these labs are considered not of medical necessity, investigative, and exploratory. All follow-up labs are not included in the Plans and are billed to your insurance. On request, follow-up labs can be billed to our account with our contracted costs.*** I agree to comply with the designed treatment plan on a timely fashion as ordered by Peggy H. Fishman, MD. Failure to perform these studies on a timely basis may affect the benefits and safety of the treatment. Termination from treatment may be an option selected, by Peggy H. Fishman, MD & the Center for Integrative and Age-Management Medicine, if there is poor patient compliance. Patients are encouraged to comply fully with follow-up exams and diagnostic labs/studies requested for a successful program.

I agree and consent to treatment by the Center for Integrative and Age-Management Medicine and Peggy H. Fishman, MD (inclusive of Peggy H. Fishman, MD and staff of Peggy H. Fishman, MD).

____
Signature

____
Printed Name

____
Witness Signature Printed Name

____
Date Time

This form can be completed at the time of the first appointment ☺

OUR INSURANCE POLICY:

We do not accept assignment from insurance companies nor are we a contracted healthcare provider.

Our goal is to prevent disease and promote wellness, these medical services are not covered by most insurance companies. However, if you have insurance coverage and would like to send a claim of your first visit and baseline Plan I or II lab tests, we will provide you with an insurance-ready receipt or a superbill. This will be provided on request after receiving your payment and being seen for your first clinic appointment. Any reimbursement from insurance is to be paid directly to you. We can NOT guarantee that the insurance company will reimburse any amount or apply the expenses to your deductible. There are 1000's of insurance policies and companies and all differ state to state. Their policies are all different and very complex.

Medicare and Medical insurance do not cover preventive medicine, and do not agree with the proactive approach our motivated patients want and which we recommend and practice. Most insurances have adopted a "managed care" approach to medicine that waits for illness to appear before they will "authorize" payment for treatment. In addition, many, if not most, of the Anti-Aging and Wellness interventions and tests are not covered by insurance. Our patients do take advantage of insurance coverage to bill all follow-up and annual lab testing. ☺ Medicare is also billed for all follow-up and annual labs. On request, if a patient has a high deductible, they can take advantage of our low contracted LabCorp/Quest Diagnostic rates and we will bill account. Payment will be due immediately for these billed labs to our account.

While some insurance carriers are covering hormone treatments, the Center for Integrative Medicine and Age-Management Medicine offices do not file insurance claims. We are a private pay facility. The IRS does allow flex spending accounts, medical savings and heath savings accounts for these services, and we can provide proper documentation for this. IAAM also offers other payment options like all major credit cards & Care Credit programs.