

NEW PATIENT HISTORY AND PHYSICAL FORM

Patient's Name: _____ Date of Birth: ____/____/____ Age: _____

Body part being seen for: _____ Side of Body (*circle*): Right Left Both

Date symptoms began: _____ Was there an *injury*? (check) Yes No

If so, how did it happen?: _____

Does the pain *spread/radiate* anywhere (ex. Arms, legs)? _____

Associated symptoms (ex. Numbness/tingling or muscle weakness)? _____

How *severe* is the pain: zero being no pain and 10 being the worst pain imaginable?

1
 2
 3
 4
 5
 6
 7
 8
 9
 10

Quality: What does the pain feel like? Constant -or- Intermittent

Aching
 Burning
 Sharp
 Stabbing
 Pressure
 Other: _____

What makes the pain *worse*? _____

What makes the pain *better*? _____

Have you had any of the following symptoms (*circle*):

- Fall within the past month
- Bowel/Bladder Incontinence or Severe Constipation
- Lack of sensation in the saddle region
- Fever, Night sweats, or severe chills

Does the pain affect your enjoyment of life (*please explain*): _____

Does the pain limit your general activity level (*please explain*): _____

Current or Prior Pain Treatment/Therapies (please state if helpful or not helpful):

- | | |
|---|--|
| <input type="checkbox"/> Heating pad or hot tub | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Ice pack | <input type="checkbox"/> Chiropractic Care: _____ |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Medication(s): _____ |
| <input type="checkbox"/> Acupuncture or Massage | <input type="checkbox"/> Injection(s)/ Procedure(s): _____ |

Follow My Health Patient Portal Instructions

Thank you for choosing Baptist Health Care for your health needs. We want to help empower you in your health goals. Managing and accessing your care is easy and convenient with Baptist Health Care Patient Portal powered by Follow My Health. Register for this platform to:

- Review your medical information in a safe, secure environment.
- Communicate with clinical team via secure messaging.
- View test results, medications, allergies, conditions, discharge instructions, and education material.
- Request prescription renewals.

Use the Follow My Health Registration link sent to the personal email address you provided and complete the next three steps to sign up and connect. If you have not shared your email address to receive an invitation to our patient portal, you can choose to share it any time in the future by contacting your physician's office.

- 1) **Click Sign Up and Connect.** If you already have a portal account and want to connect with an additional provider, click Sign in and add this connection (skip to step 3)
- 2) **Create a username for your portal account.** By default, this will be your email address. Next, create a password following the criteria noted on the right of the screen. Confirm your password to continue.
- 3) **Connect your account.** Follow the on-screen prompts to complete your account connection. These screens include accepting our Terms of Service, entering your Invite Code [the last four digits of your social security number or your year of birth] and accepting the release of information.

You will then be ready to access and manage all of your personal health information in a secure location **24 hours a day/ 7 days a week** using any computer, smartphone or tablet.

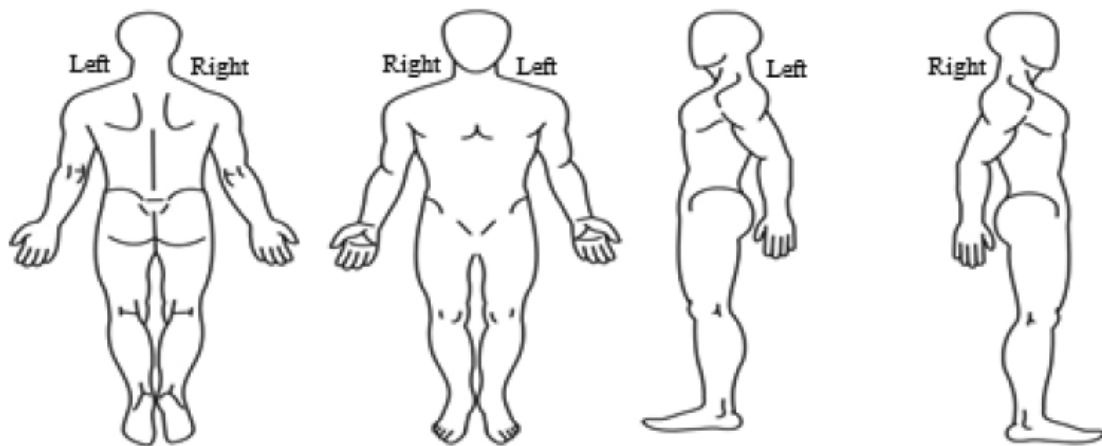
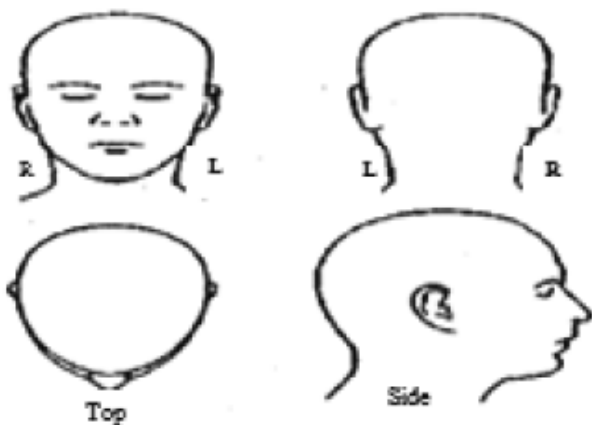
If you have any questions regarding the registration process, please contact FollowMyHealth Support Services at 1.888.670.9775 or email noreply@followmyhealth.com

Please use the following symbols to indicate the type and location of your pain on the drawings below.

<u>TYPE OF PAIN</u>	<u>SYMBOL</u>
Sharp.....	X
Shooting.....	->
Burning.....	B
Aching.....	A
Spasming.....	S
Tingling.....	T
Numbness.....	N

EXAMPLE:
Types of pain:
Sharp and burning

Location of pain:
Back of neck down
To right shoulder blade



GENERAL MEDICAL INFORMATION

Who is your primary care doctor? _____ Date of last visit: _____

Do you take blood thinning medication (circle): Yes, name: _____ No

Are you pregnant or attempting to get pregnant (circle): Yes No

Occupation: _____

Are you disabled? Yes No If yes, explain: _____

1. **ALLERGIES:** Please list any **allergies** and reactions to medications/substances in the PAST: or (circle) NONE

MEDICATION	REACTION	MEDICATION	REACTION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

2. **PHARMACY:** Name: _____ Location: _____

3. **MEDICATIONS:** Please list any **medication** you are currently taking:

MEDICATION	DOSE/FREQ	MEDICATION	DOSE/FREQ
1)		9)	
2)		10)	
3)		11)	
4)		12)	
5)		13)	
6)		14)	
7)		15)	
8)		16)	

4. **PAST MEDICAL HISTORY:** Check if you had any of these **medical problems** in the PAST: or (circle) NONE

ILLNESS	Y	ILLNESS	Y	ILLNESS	Y
Anemia		Heart Attack		Peripheral Vascular Disease	
Anxiety		Heart Failure		Psychiatric Illness: _____	
Asthma		Heart Murmur		Pulmonary Embolism	
Bleeding Problems		Hepatitis B		Reflux	
Blood Clot		Hepatitis C		Rheumatoid Arthritis	
Cancer: _____		High Blood Pressure		Sjogren's Disease	
Chest Pain/ Angina		HIV/AIDS		Skin Ulcer/ Breakdown	
COVID-19		Immune Deficiency		Sleep Apnea	
Deep Vein Thrombosis		Kidney Disease		Steroid Use	
Depression		Latex Allergy		Stroke	
Diabetes		Liver Disease		Thyroid Disease	
Gall Bladder Disease		Lupus		Tuberculosis- TB	
Gastric Ulcers		MRSA (resistant staph)		Urinary Infections	
Glaucoma		Neuropathy		Valve Disorders (heart)	
Gout		Osteoarthritis		Wound Healing Problem	
Heart Arrhythmia		Paralysis			

List any **other medical problems** NOT listed above:

5. **PAST SURGICAL HISTORY:** Please list any **operations/surgeries** you had in the PAST: or (circle) NONE

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		7)	
2)		8)	
3)		9)	
4)		10)	
5)		11)	
6)		12)	

6. **PAST FAMILY HISTORY:** Please list major immediate **family medical problems:** or (circle) NONE

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

7. **SOCIAL HISTORY:** Please circle status use of the following:

Cigarette: Never Former Current Cigarettes per day: _____ Years: _____

Other tobacco: Never Former Current Type: _____ Years: _____

Alcohol: Never Former Current Drinks per day: _____ Type: _____

Illicit Drugs: Never Former Current Type: _____

REVIEW OF SYSTEMS: Please mark any of the symptoms you are experiencing TODAY:

<p>GENERAL</p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other: _____</p>	<p>SKIN</p> <p><input type="checkbox"/> Lesions <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Skin color change <input type="checkbox"/> Other: _____</p>	<p>NOSE</p> <p><input type="checkbox"/> Congestion <input type="checkbox"/> Discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sneezing <input type="checkbox"/> Decreased sense of smell <input type="checkbox"/> Other: _____</p>
<p>EYE</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Pain <input type="checkbox"/> Photophobia <input type="checkbox"/> Vision Changes <input type="checkbox"/> Dryness <input type="checkbox"/> Other: _____</p>	<p>EAR</p> <p><input type="checkbox"/> Hearing Disturbance <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Pain <input type="checkbox"/> Tinnitus <input type="checkbox"/> Other: _____</p>	<p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest Pain <input type="checkbox"/> Lower extremity swelling <input type="checkbox"/> Shortness breath lying down <input type="checkbox"/> Palpitation <input type="checkbox"/> Fainting <input type="checkbox"/> Feels faint at times <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Other: _____</p>
<p>MOUTH/THROAT</p> <p><input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Lesions <input type="checkbox"/> Dental Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Voice Changes <input type="checkbox"/> Dryness <input type="checkbox"/> Other: _____</p>	<p>RESPIRATORY</p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Sputum production <input type="checkbox"/> Other: _____</p>	<p>GENITOURINARY</p> <p><input type="checkbox"/> Pain with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary hesitance <input type="checkbox"/> Urinary inconstance <input type="checkbox"/> Change in bladder habits <input type="checkbox"/> Other: _____</p>
<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Stool inconstance <input type="checkbox"/> Other: _____</p>	<p>NEURO</p> <p><input type="checkbox"/> Confusion/ memory loss <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Change in speech <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Difficulty with ambulation <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of balance <input type="checkbox"/> Seizures <input type="checkbox"/> Unusual sensation <input type="checkbox"/> Other: _____</p>	<p>PSYCH</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Insomnia <input type="checkbox"/> Mood problems <input type="checkbox"/> Fearful <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Delusions <input type="checkbox"/> Other: _____</p>
<p>MUSKULOSKELETAL</p> <p><input type="checkbox"/> Pain in joints <input type="checkbox"/> Back pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Joint redness <input type="checkbox"/> Muscle pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle weakness</p>	<p>HEME/LYMPH</p> <p><input type="checkbox"/> Bleed/bruise easily <input type="checkbox"/> Enlarged/tender lymph nodes <input type="checkbox"/> Night sweats <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____</p>	<p>ENDOCRINE</p> <p><input type="checkbox"/> Change in weight <input type="checkbox"/> Cold/heat intolerance <input type="checkbox"/> Hot flashes <input type="checkbox"/> Excess thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Appetite changes <input type="checkbox"/> Other: _____</p>
		<p>GYNECOLOGICAL</p> <p><input type="checkbox"/> Change in menses <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Other: _____</p>

Patient Registration Form

Last Name:	First Name:	MI:
------------	-------------	-----

Social Security: ____ - ____ - ____	Date of Birth: ____/____/____
-------------------------------------	-------------------------------

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Additional gender category or other <input type="checkbox"/> Choose not to disclose. <input type="checkbox"/> Female-to-Male (FTM)/Transgender <input type="checkbox"/> Genderqueer, neither excl male or female <input type="checkbox"/> Male-to-Female (MTF)/Transgender	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Legally Sep <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown <input type="checkbox"/> Married
--	---

Address:	City:	State:	Zip:
----------	-------	--------	------

Email:

Primary Phone: (____) ____ - ____ <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone	Secondary Phone: (____) ____ - ____ <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone
--	--

Preferred Language: _____

Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown/Decline to Answer	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Decline to Answer	U.S. Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawfully present in the U.S. <input type="checkbox"/> Not lawfully present in the U.S. <input type="checkbox"/> Decline to Answer
--	--	---

Responsible Party: This section refers to the person/party who should receive the bill

Relationship to Patient: <input type="checkbox"/> Self (skip this section) <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other

Last Name:	First Name:	MI:
------------	-------------	-----

Social Security: ____ - ____ - ____	Date of Birth: ____/____/____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
-------------------------------------	-------------------------------	---

Address:	City:	State:	Zip:
----------	-------	--------	------

Primary Phone: (____) ____ - ____	Secondary Phone: (____) ____ - ____
-----------------------------------	-------------------------------------



Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant verbal discussions regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.

I understand that information may be released to family members or others without this form, if allowed by federal and state law.

I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.

I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.

I can update this form at any time by completing a new form and giving it to BMG staff.

I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.

I understand that this is not a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature	_____	
Print Name	_____	
Date	___ / ___ / ____	Time ___ : ____

Relationship to Patient

Self

Legal Representative or Guardian (proof of power of attorney or legal guardianship required)

