ReliableMD

PATIENT MEDICAL HISTORY

Date: ____/____/_____

Patient name: ____ **Gender** M F U **DOB**: _________________

Height _________ **Weight** _____________

Past Medical History (Please answer all questions to the best of your ability):

Do you now or have you had:

	YES	NO		YES	NO
Tuberculosis (TB)			Thyroid Disease		
Cancer (type)			Stomach Disease (ulcers, reflux)		
High blood pressure			Intestinal Disease		
Diabetes (sugar high/low)			Liver Disease		
Heart attack			Seizures		
Kidney Disease			Urinary issues		
Lung Disease			Other:		

Please explain all of the "YES" answers: ____

____

Habits: Do you now or have ever used: *(Circle yes or no)*

1) Tobacco (cigarettes, chew, pipes, vape, etc) YES NO

If yes, how long? _______ years. Quit? YES NO

2) Alcohol (beer, liquor, wine, etc) YES NO

If yes, how long? _______ years. YES NO

3) Caffeine (soda, coffee, tea, energy drinks, etc) YES NO

How many per day? _________

4) Illicit drugs (injected, inhaled, etc) YES NO

If yes, quit? YES NO Total years ________

Medication Allergies/Intolerance (Reaction):

1)________________________ → ________________________

2)________________________ → ________________________

3)________________________ → ________________________

4)________________________ → ________________________

Food and Environmental Allergies (Reaction):

1)________________________ → ________________________

2)________________________ → ________________________

3)________________________ → ________________________

4)________________________ → ________________________

Prior Surgeries (Dates if known):

1)___________________________________

2)___________________________________

3)___________________________________

4)___________________________________

5)___________________________________

Medications Taken Routinely (w/ doses)

1)___________________________________

2)___________________________________

3)___________________________________

4)___________________________________

5)___________________________________

6)___________________________________

7)___________________________________

8)___________________________________

9)___________________________________

10)__________________________________

11)__________________________________

RELIABLE MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RELIABLE MD requests that patients obtain all records relevant to their appointment with the office. This information may be brought with you or faxed to the office prior to your appointment. It is the patient's responsibility to provide these records. FAILURE TO PROVIDE THESE RECORDS MAY NECESSITATE RESCHEDULING THIS APPOINTMENT.

Instructions: Please complete and sign this authorization and forward it to the appropriate facility to obtain records. If you complete the record request we would be happy to fax this for your at your request. Thank you!

TO:___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

REQUESTED RECORDS:
- ◯ All office notes prior
- ◯ All pulmonary function tests/spirometry/6 minute walk tests
- ◯ All chest imaging (chest xray, CT chest, ultrasound, etc)
- ◯ All pertinent clinical notes
- ◯ All laboratory studies
- ◯ Other ____

I hereby authorize you to release my medical records. I understand that my records may contain information about drug or alcohol abuse, communicable diseases, HIV testing or results of psychiatric or psychological conditions.

Released records may be sent to **RELIABLE MD**

FAX preferred **5045 Fruitville Rd Suite 123B Sarasota, FL 34232**

PHONE: 727-203-4613 FAX: 727-203-4613

If there are NO RECORDS, please indicate here: ____

Patient Name: ____ Date: ____________________________

Date of Birth: ______________________ Previous name(s) if applicable: ______________________________

Patient signature (over age 18) ____

Personal Representative name & signature (if under 18) ____