COMPREHENSIVE MEDICAL HISTORY FORM

Please complete this form. This is a confidential part of your medical record and it will be scanned, then shredded. The digital copy will be kept in our e-file library as a permanent part of your **E**lectronic **H**ealth **R**ecord, **EHR**. All the information contained in this form, throughout all the three pages, **WILL NOT BE** released to any person(s) or entity (ies) without your written authorization and consent as mandated by HIPAA and medical privacy laws and etiquettes.

NAME _____ **AGE** _____ **RACE** _____ **GENDER** _____

DATE OF BIRTH _____ / _____ / _____

PAST MEDICAL HISTORY:

Approximate Date of Diagnosis

- _____
- _____
- _____
- _____
- _____
- _____

MAY USE ADDITIONAL SHEET IF MORE SPACE IS NEEDED.

PAST SURGICAL HISTORY: **Surgeries or operations** you have had in the past.

Type of surgery Date Complications if any

- _____
- _____
- _____
- _____
- _____
- _____
- _____

ALLERGIES: Please circle what you are allergic to. If not allergic to anything CIRCLE **NONE**

- Penicillin Sulfa IV Dye Iodine Shell fish or seafood ACE-Inhibitors
- Describe the reaction:

_____

List **ANY other** substances to which you are **ALLERGIC** to and are not mentioned above: _____

Please, describe the reaction: _____

HAVE YOU USED ARTHRITIS and PAIN MEDICATIONS: NSAIDS: Please Circle one YES NO

HAVE YOU USED PROTON PUMP INHIBITORS: PPIs: Heartburn or ULCER MEDICATIONS: YES NO

NAME AND SIGNATURE: _____ DATE: _____

THE VIRTUAL NEPHROLOGIST

SOCIAL HISTORY:

1- Current Occupation: _____
If retired, please list previous occupation: _____

2- Marital Status: __ Married ___ Divorced ___ Living with someone ___ Single ____ Widowed

3-Habits:

Smoking I do not smoke and have never smoked _____
I do not smoke now but used to smoke _____ Packs per day _____
For how many years? _____ Date you quit _____
I **presently** smoke _____ pack(s) per day for the past _____ years.

Vaping I do not Vape any more _____ I have never Vaped _____-

Alcohol Do you consume alcoholic beverages now? **(Circle one) Yes No** Prefer not to answer
Have you ever had a "drinking" problem"? **(Circle one) Yes No** Prefer not to answer

Drugs Do you currently use **OR** have you ever used recreational or intravenous drugs?
(Circle one) Yes No Prefer not to answer

4-Occupational or chemical exposures and world travel:

_____

FAMILY HISTORY:

	If Living		**If deceased**	
	Current age	Medical problems	Age and year of death	Cause of death
Father				
Mother				
Brothers				
Sisters				
Children				

Have any of your immediate blood relatives ever had: Check if **YES? Who**_____
Heart Disease _____ Sickle Cell Disease _____ Diabetes_____ Stroke____ Kidney Disease_____
Dialysis_____ High Blood pressure _____ Polycystic Kidney Disease_____ Cancer_____

MEDICATIONS: Please list the name, dose and frequency. **May use additional sheet if more space is needed.**

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

NAME AND SIGNATURE: _____ DATE: _____

THE VIRTUAL NEPHROLOGIST

Please, list all “over the counter” medications, especially arthritis medications, such as NSAIDS, herbal medications, or (**AMT**s “**A**lternative **M**edical **T**herapies”) or natural remedies. **If none circle: NONE**

_____

Are you up to date on your IMMUNIZATIONS? **YES** **NO** **DO NOT KNOW** **(circle one)**

___ Flu ___ Pneumonia ___ Hepatitis B ____ Tetanus ____ Zoster

REVIEW OF SYSTEMS: Please, check ✔ **YES or NO BOX** if you **currently** have or **recently** had the following:

Problem	YES	NO	Problem	YES	NO
Recent unintentional weight changes			Lupus		
Poor appetite			Stomach pains or Ulcers		
Recurrent Fevers or night sweats			Acid reflux or heart burns		
Spots before eyes or Diabetic eye disease			Nausea or vomiting		
Blurred, double vision			Hiatal hernia		
Ringing in ears			Bloody or black tarry Stools		
Mouth sores, ulcers or thrush			Diverticulitis		
Difficulty or painful swallowing			Hemorrhoids		
Nosebleeds			History of internal bleeding		
Frequent or severe headaches			Hepatitis C and/or yellow Jaundice		
Sinus trouble			Chronic Diarrhea		
Coughing up blood			Gallbladder Problems		
Asthma or wheezing			Colitis		
Snoring or sleep apnea			Constipation		
Bronchitis or emphysema			Dribbling at the end of urination		
Swelling of your legs and/or ankles			Trouble emptying bladder		
Shortness of breath			Wake up at night to urinate, how many times		
Chest pains or angina			Lose urine control on coughing or sneezing		
Dizziness or fainting spells			Kidney Stones, if yes which side		
Persistent Cough			Difficulty starting urine		
Heart Attacks or Myocardial Infarctions			Blood in urine		
Wake up at night with shortness of breath			Anemia		
Leg cramps on walking			Blood Clot in legs or lungs		
Irregular Heartbeat, palpitations			Easy bruising		
Congestive Heart Failure			Prolonged bleeding or free bleeder		
Weakness or numbness one side of body			Previous blood transfusion		
Stroke or TIA			Enlarged glands or lymph nodes		
Tingling in feet and/or hands			Skin rashes or lesions		
Memory Loss			AIDS or HIV Positive		
Diabetes			Changes in your hair, greying or thinning		
Thyroid disease			Skin Problems		
Are you excessively thirsty			Joint pains or Arthritis?		
Gout			Back Pains		
For women: Irregular or heavy periods			Muscle aches		
For Men: Erectile Dysfunction			OTHER:		

NAME AND SIGNATURE: _____ DATE: _____

Tel: (929) 379.6953 https://thevirtualnephrologist.com/ fax: (850) 914.3004

The Virtual Nephrologist, INC.

THIS NOTICE DESCRIBES HOW MEDICAL AND FINANCIAL INFORMATION ABOUT YOU, AS A CLIENT OF THE VIRTUAL NEPHROLOGIST, INC., MAY BE USED AND/OR DISCLOSED

PLEASE REVIEW CAREFULLY

Relationships are built on trust. One of the most elements of trust is respect for an individual's privacy. We, at The Virtual Nephrologist, Inc., value our relationship with you, and we take your personal health and financial information privacy very seriously. The privacy of your health and financial information is important to us.

YOU DO NOT NEED TO DO ANYTHING UNLESS YOU HAVE A REQUEST OR A COMPLAINT

For purposes of this Notice, "us", "we" and "our" refers to The Virtual Nephrologist, Inc. "You" or "your" refers to our clients (or their legal representatives). When you receive virtual consultation services from us; we will obtain access to your medical information (e.g., your health history that you provide). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so. **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 **(HIPAA)** require us to maintain the confidentiality of all your healthcare records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally, your PHI is protected and secure. HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. Starting April 14, 2003, HIPAA requires us to provide you with this Notice of our legal duties and the privacy practices we are required to follow when you first contact us for virtual consultation services. If you have any questions about this notice, please ask to speak to our privacy officer. Our Physicians at The Virtual Nephrologist, Inc., follow the policies and procedures set forth in this notice.
You may choose to not use your name and just ask questions and request research assistance. We will not ask you details of personal, health and medical or financial information you do not want to disclose.

OUR RULES on how we may use your Protected Health Information, PHI

We DO NOT store any financial or medical information about you after conclusion of the Virtual Consultation.
We DO NOT disclose any financial or medical information to any third party without your request.
We DO NOT Video or audio record our virtual consultations. We request you DO NOT VIDEO or AUDIO RECORD TOO. We do not give a consent to audio or video record any or part of the consultations.
We DO NOT ask for information you do not want to share with The Virtual Nephrologist, Inc.
We destroy any and all information about you, including e-mails, paper records and electronic records and we provide you with a certificate of destruction of such information at the end of a virtual consultation service if you chose or request so.
We will take all reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when you share it.
We reserve the right to change our privacy practices by changing the terms of this Notice at any time.

GENERAL DISCLAIMER

The relationship between The Virtual Nephrologist, Inc. and you is NOT a Doctor Patient relationship. It is an advice and education regarding medical matters related to Hypertension, Kidney Disease, Dialysis or Heart Failure. We also provide you with guidance and assistance in research about medical matters you are interested in.

THIS SITE IS NOT AND SHOULD NOT BE USED FOR EMERGENCY MEDICAL NEEDS.IF YOU EXPERIENCE A MEDICAL EMERGENCY CONTACT YOUR LOCAL EMERGENCY SERVICES IMMEDIATELY, DIAL 911 OR GO TO THE NEAREST EMERGENCY ROOM. WE DO NOT OFFER OR PROVIDE MEDICAL PERSCRIPTIONS.

THIS SITE IS NOT ANALTERNATIVE TO CONVENTIONAL MEDICAL CARE. THE SITE IS ONLY FOR YOUR ADDITIONAL UNDERSTANDING OF HYPERTENSION, KIDNEY DISEASE, DIALYSIS AND CONGESTIVE HEART FAILURE VIA QUESTIONS AND ANSWERS AND ASSISTANCE IN RESEARCH ABOUT YOUR CONDITION OR QUESTIONS.

https://thevirtualnephrologist.com/
PO Box 1750
Lynn Haven, FL 32444, USA

revised 05212020

The Virtual Nephrologist, INC.

ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(PLEASE READ CAREFULLY, COMPLETE and SIGN, then E-MAIL OR FAX BACK TO US)

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES", revision date of May 21, 2020.
As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.
Requests ONLY IF YOU WANT TO CHANGE ANYTHING otherwise SKIP and sign below:

____ I wish to file a "Request for Restriction" of my Protected Health Information.

____ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

____ I wish to object to the following in the "Notice of Privacy Practices":

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original or previous version(s).

Signature: _____ Date signed_____ Printed Name: _____

CONSENT

I give The Virtual Nephrologist, Inc. and A. O. Rifai, MD my consent to use my Protected Health Information to carry out my Virtual consultation and to obtain payment from me via PayPal or other means, direct e-mail billing to my e-mail of record.

I understand for any medical emergencies I should call 911 or go to the nearest ER.

I understand for any “time sensitive matter”, I should not use the internet. I understand that e-mails, or Zoom may not be HIPAA compliant.

I understand that The Virtual Nephrologist, Dr. Rifai is not my treating physician and for my ultimate decision and medications and direct patient care, I should see my primary care physician and any consultant I follow with, including Nephrologist or a Cardiologist.

Signature: _____ Date signed_____ Printed Name: _____

DO NOT WRITE BELOW THIS LINE_____

For Office Use Only: received by: _____ Date: _____

https://thevirtualnephrologist.com/

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