Health History & Review of Systems Questionnaire

Lindenwood Student Health Center

Name: _____

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

Allergies

Please list any medications to which you are allergic: ❑ None

_____

Are you allergic to latex? ❑ No ❑ Yes

Are you allergic to anything else? ❑ No ❑ Yes

If Yes, please list: _____

Current Medications ❑ None

Please list all medications taken regularly during the past month (include over-the-counter medication, vitamins, herbals, supplements, etc.):

Name	Dose	Times per day

Current or Past Conditions

Circle all that apply ❑ **No chronic or active disease**

High blood pressure	Diabetes	Asthma/COPD	Headache/migraines
Heart attack/stents	Hepatitis	Sleep apnea	Concussion
Heart disease or failure	Liver disease	Seasonal allergies	Depression/anxiety
Stroke/TIA	Bleeding disorder	Tuberculosis	Psychiatric problem
High cholesterol	GERD/reflux	Kidney disease	Alcohol abuse
Cancer	Carpal tunnel/disorder	Peptic ulcer/colitis	Substance abuse
Eye/glaucoma	Thyroid condition	Arthritis/fibromyalgia	Prior pain management
Rheumatic fever	Epilepsy/prior seizure	Skin rash	

Describe if yes/other condition: _____

_____

Are you left- or right-handed? ❑ Left ❑ Right

Are you pregnant or breastfeeding? ❑ No ❑ Yes

Prior Surgeries, Major Injuries or Hospitalizations

❑ I have not had any surgeries ❑ I have not had any hospitalizations

Please include month and year and left/right body part: _____

_____

_____

_____

Name: _____ **Date of Birth:** _____

Review of Systems

Have you experienced any of these symptoms in the past month? *(Circle symptoms or check no symptoms)*

	No Symptoms					
General	❑	Fever	Weight loss	Fatigue		
Eyes	❑	Blurred vision	Redness	Discharge		
ENT	❑	Hearing loss	Ringing in ears	Sore throat		
Cardiac	❑	Chest pain	Palpitations	Edema		
Respiratory	❑	Cough	Wheezing	Short of breath		
GI	❑	Abdominal pain	Nausea/vomiting	Loss of bowel control	Diarrhea	Constipation
GU	❑	Painful urination	Urinary hesitancy	Loss of bladder control		
Joint/muscle	❑	Joint swelling	Stiffness	Joint pain, where? _____		
Skin	❑	Rash	Itching	Pigment change		
Neurologic	❑	Headache	Dizzy	Numbness	Tingling	Seizures
		Loss of consciousness				
Psych	❑	Depression	Anxiety	Suicidal thoughts		
Endocrine	❑	Heat intolerance	Weight gain	Change in hair		
Allergy	❑	Itchy eyes	Hay fever	Hives		
Heme	❑	Easy bruising	Easy bleeding	Swollen lymph nodes		

Social History

Smoking tobacco:	❑ Currently	❑ Quit	❑ Never		
Chewing tobacco:	❑ Currently	❑ Quit	❑ Never		
Alcohol:	❑ Currently	❑ Quit	❑ Occasionally	❑ Never	❑ Other

Safety

Comments

_____

_____

_____

Family History

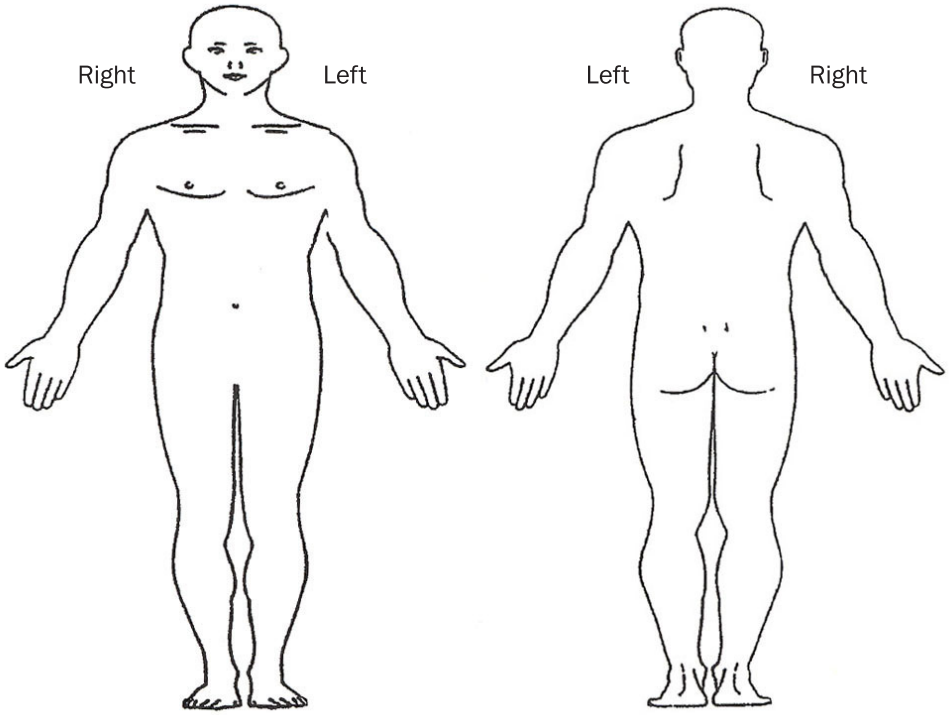
Do you have a blood relative (parent, grandparent, brother or sister) with:

Asthma	Cancer	Diabetes	Heart disease
Hypertension	Kidney disease	Other: _____	
Neurological condition	Psychiatric condition		

Name: _____ **Date of Birth:** _____

Pain Diagram

Mark the areas of the body where you feel the described sensations with the appropriate symbols for those sensations from the chart to the right:



Numbness	++++++
Burning	XXXXXX
Pins and Needles	000000
Sharp	//////
Dull and Aching	******
Weakness	VVVVV

Check the box that best represents your current pain level:

0	1	2	3	4	5	6	7	8	9	10
No pain		Slight pain		Moderate pain			Severe pain		Unbearable pain	

_____

Signature Date

_____ ❑ Discussed blank fields with patient

Medical Technician Signature Date

_____

Provider comments:

_____

Provider Signature Date

BJC HealthCare

Lindenwood Student Health Center

Consent for Communication

As a patient of Lindenwood Student Health Center, I am giving my consent to release medical information, including test results, diagnosis and treatment dates, to the following individuals:

Name	Relationship	Date

Name	Relationship	Date

You may leave medical information on voice mail at these phone numbers:

Home	Cell

Preferred method to reach you:

❑ Home phone ❑ Cell phone ❑ Text message

❑ Other: _____

Please make sure you have provided your cell phone number if cell phone or text message is your preferred contact method.

Additionally, I understand that this consent must be revoked in written form, should I choose to do so.

Patient signature	Date

Lindenwood Student Health Center

BJC Corporate Health Services

Authorization for Release of Information or Individual Access to Information

❑ I hereby authorize/request BJC Corporate Health Services, d/b/a BarnesCare, to release, disclose or grant me access to the medical information of:

_____.
Patient's full name

❑ I hereby authorize/request _____
(name/address of provider), to release to BJC Corporate Health Services, d/b/a BarnesCare, the medical information of:

_____.
Patient's full name

Former name(s) (where applicable): _____

Date of birth: _____ Social Security #: _____

I request only the following information to be released/accessed:

- ❑ Medication list
- ❑ Emergency report
- ❑ History & physical
- ❑ Operative report
- ❑ Pathology report
- ❑ X-ray reports
- ❑ X-ray films
- ❑ Cardiac cath lab reports
- ❑ EKG
- ❑ Charting notes of provider, within the past year
- ❑ Lab results (specify): _____
- ❑ Other (specify): _____

Date(s) of treatment: _____

Release or mail to: _____
Individual/Physician/Institution/Agency

_____
Street address

_____
City, State, Zip Code

_____
Telephone Number

For the purpose of: _____
(For patient request, state "Self.")

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential." I permit the release of all information indicated above, including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither BJC Corporate Health Services d/b/a BarnesCare nor any of its affiliated health care providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I choose to receive it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is requested from.

If this authorization is being presented pursuant to litigation, complete this section.

If this Authorization is being completed pursuant to litigation, please note that this Authorization includes medical records, reports and other medical documents in your possession that relate to any prior or subsequent complaints, injuries, illnesses or other conditions involving the same parts of the body and the same or similar conditions as described below. This Authorization includes, but is not limited to, records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRIs and CT scans and postmortem records, if applicable, **PROVIDED** that the examinations, treatments and/or tests involve or relate to complaints, injuries, illnesses or conditions pertaining to the following alleged injury:

_____

[insert allegation from petition, which describes injured part(s) of body]

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability.

This authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

[The patient further requests that the health care provider supply complete copies of all documents produced pursuant to this authorization to patient's attorneys, _____, at their expense (If desired by Plaintiff's counsel)].

Note: Records will be mailed to above address unless otherwise noted below.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative *Date*

_____ _____

If someone else signs on behalf of the patient, state your relationship to the patient. *Date*

_____ _____

Witness *Date*

Note: If above address is not patient's, please complete the following:

Patient address: _____

Check if patient will pick up copies at [facility]: ❑

_____

Facility use only: *Date access/request granted:* _____

Other disposition (date/action): _____