Patient History Questionnaire
(Please fill out completely)

Office Use Only
Date _____
HT _____ WT _____
T _____
HR _____
RR _____
BP _____
Sat _____

Patient Name _____ Age _____

Date of Birth _____

Medical Doctor _____

Cardiologist _____

What is the reason for today's visit? _____

_____

Medical History

High Blood Pressure	____ Yes	____ No
Diabetes	____ Yes	____ No
Stroke or mini-stroke	____ Yes	____ No

Surgical History

List all prior surgeries _____

_____

_____

_____

List all prescriptions and over-the-counter medications you are currently taking, including dosage and how often you take it

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies you have

_____

_____

Family History

Has anyone in your family ever had heart disease? ____ Yes ____ No

If so, what is their relation to you _____

Has anyone in your family ever had lung disease? ____ Yes ____ No

If so, what is their relation to you _____

Social History

Are you married? ____ Yes ____ No ____ Divorced ____ Widowed

Number of children _____

Who do you live with? _____

Do you smoke? ____ Yes ____ No ____ # packs per day

Have you quit smoking? ____ Yes ____ No When? _____

Do you drink alcohol? ____ Yes ____ No How much? _____

Are you employed? ____ Yes ____ No ____ Retired

Type of employment _____

Other Medical Problems

Visual Problems	____ Yes	____ No
Date of last dental visit	_____	
Do you need dental work	____ Yes	____ No
Lung disease	____ Yes	____ No
Asthma	____ Yes	____ No
Tuberculosis	____ Yes	____ No
Bronchitis	____ Yes	____ No
Coughing up blood	____ Yes	____ No
Heart disease	____ Yes	____ No
Heart attack	____ Yes	____ No
Waking up short of breath	____ Yes	____ No
Can you lie flat and sleep	____ Yes	____ No
Rhythm problems	____ Yes	____ No
Heart murmur	____ Yes	____ No
Rheumatic fever	____ Yes	____ No
Stomach problems	____ Yes	____ No
Stomach ulcer	____ Yes	____ No
Gastric Reflux (GERD)	____ Yes	____ No
Diverticulitis	____ Yes	____ No
Bloody stools	____ Yes	____ No
Colon polyps	____ Yes	____ No
Colon cancer	____ Yes	____ No
Kidney or Bladder problems	____ Yes	____ No
Kidney stones	____ Yes	____ No
Recurrent bladder infections	____ Yes	____ No
Kidney failure	____ Yes	____ No
Dialysis	____ Yes	____ No
Prostate problems	____ Yes	____ No
Liver problems	____ Yes	____ No
Jaundice	____ Yes	____ No
Bleeding problems	____ Yes	____ No
Free bleeder	____ Yes	____ No
Blood transfusion	____ Yes	____ No
Arthritis	____ Yes	____ No
Gout	____ Yes	____ No
Cancer	____ Yes	____ No
If yes, location and treatment	_____	

_____

Seizures	____ Yes	____ No
Passing out spells	____ Yes	____ No
Skin rashes	____ Yes	____ No
Prior leg vein stripping	____ Yes	____ No
Other medical problems	_____	

_____

_____

Patient Name:_____ **Date:**_____
Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS: _____	**SCORING:** 6 = High (*patient independent*)	0 = Low (*patient very dependent*

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

UNC HEALTH CARE

Patient Name_____
Date of Birth_____

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.[1] I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____
Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Name: _____ Phone Number: _____
Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

_____ DATE: _____ TIME: _____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

Chart Location: Consents

HIM1315

Rex Healthcare
Raleigh, NC 27607

Patient Rights and Responsibilities

You have the right at Rex Hospital, Inc. to:

1. Receive care that is free of discrimination and is respectful of your personal privacy, personal value, dignity, and beliefs. Rex prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.

2. Be cared for in a safe and respectful environment.

3. Receive private and confidential treatment.

4. Confidentiality, privacy, and security of your healthcare information.

5. Receive visitors who you designate and withdraw or deny such consents at any time.

6. Be involved in the decisions about your treatment/care plan, discharge plan, and pain management plan.

7. Receive full information about the risks, benefits, and alternatives to your plan of care given to you in a way you can understand and through the use of an interpreter, if needed.

8. Request or refuse care/treatment to the extent permitted by law. Your care provider will explain the medical consequences of refusing recommended treatment.

9. Agree or refuse the use of recording, films, or other pictures to be used for reasons other than your care.

10. Have a family member or representative of your choice and your own physician notified of your admission to the hospital.

11. Have a family member, friend or other individual to be present with you for emotional support during your stay at Rex unless their presence infringes on others' rights, safety or is medically or therapeutically contraindicated as directed per the Rex Visitation policy.

12. Receive information about advance directives (Living Will, Healthcare Power of Attorney), obtain assistance in completion of advance directives, and have advance directives honored once legally executed and available on the medical record.

13. Be involved in end of life care decisions to include withholding life sustaining treatments, resuscitative services, and organ/ tissue donation.

14. Request a discharge planning evaluation at any time during your stay.

15. Know the name and role of your care providers (doctor, nurse, etc.) and know who is primarily responsible for your care.

16. Request to see information contained in your medical record, and request changes to be made in your medical record.

17. Know to whom your information has been disclosed.

18. Be free from abuse, neglect and harassment and to receive our help in contacting advocacy or protective services.

19. Be free from restraint and seclusion that is not medically required or is used inappropriately.

20. Receive medically necessary treatment regardless of your ability to pay.

21. Be informed of charges and your financial responsibility. Receive financial counseling if requested.

22. Participate in or decline to participate in research. You may decline at any time without compromising your care or treatment.

23. Receive copies of your hospital bills and an explanation of charges. Be informed that Rex contracts with Raleigh Emergency Medicine, Raleigh Radiology, Rex Pathology Associates, Rex/UNC Radiation Oncology, American Anesthesiology of NC and UNC Neonatology to provide services to our patients. These physicians are independent practitioners and not employees of Rex Hospital.

24. Have complaints/grievances addressed promptly. Your complaints/grievances will not affect your access to care, treatments, or services. **Please direct your complaints/grievances to the staff delivering your care, the department management, or contact the Quality Programs Department at 919-784-7201.** You may also mail your concerns to Rex Healthcare, Quality Programs Department, 4420 Lake Boone Trail, Raleigh, NC 27607. For billing concerns, please contact UNC Healthcare Patient Financial Services Customer Service number at 1-800-594-8624.

    You may also contact:

    The Joint Commission by Phone: 1-800-994-6610 (available weekdays, 8:30 a.m. to 5 p.m. Central Time); E-mail: complaint@jointcommission.org; Fax: 630-792-5636; or Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181. Summarize the issue in two pages or less and include the name and full address of the organization in question.

    The North Carolina Division of Health Services Regulation by Phone: 1-800-624-3004 (within NC) or 919-855-4500 (available weekdays 8:30 a.m. to 4:00 p.m., except holidays); Fax 919-715-7724; or Mail: 2711 Mail Service Center, Raleigh, NC 27699-2711.

Your responsibilities are to:

1. Provide us as much information about your health and medical history as possible.

2. Ask questions when you do not understand.

3. Follow instructions for your care. If you are unable or unwilling to follow instructions, you need to tell us. You are responsible for the outcomes of not following your plan of care.

4. Act in a manner that is respectful of other patients, staff, and facility property.

5. Meet your financial responsibility to the facility to pay for your care (after any insurance payments have been made) or ask for financial assistance.

6. Follow this facility's rules and regulations.

REQUEST # _____ FIN # _____

UNC Rex Healthcare
4420 Lake Boone Trail
Health Information Management
Raleigh, North Carolina 27607
919-784-3158; Fax 919-784-3343

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize:

	UNC Health Care System	OR		Other facility:

To use or disclose to:

Name of Person or Facility: UNC REX Heart Valve & Structural Center			
Address 2800 Blue Ridge Rd., Ste. 201	City Raleigh	State NC	Zip 27607
Phone: 919-784-1321	Fax: 919-784-7111	Email: N/A	

The protected health information of:

Patient Name:		Date of Birth:	SS# (last 4):
Address	City	State	Zip
Phone:		UNC Medical Record #	

Dates of Service: _____

Put a CHECKMARK next to the specific documents that apply to your request:

	Clinic notes (outpatient)		Operative / Procedure notes		Progress Notes (inpatient)
	Emergency Dept. notes		Providers Orders		Radiology reports
	Urgent Care Center notes		Nursing notes		Patient Billing records
	History and Physical		Consultations		Film / CD (Imaging support)
	Discharge Summary		Laboratory reports		All Medical Records
Other (describe)					

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

Put a CHECKMARK next to the purpose of the request:

	Attorney/ Legal		Continued Patient Care		Insurance
	Personal Use		Social Services/ Disability		Other:

REQUEST # _____ FIN # _____

Put a CHECKMARK next to how you would like to receive your request:

	Mail to address listed above
	Review in Release department (HIM)
	Receive electronically at email above

	Fax to # listed above **(Health care providers only; no personal faxes)**
	Review remotely **(employees only with EHR Access)**
	Release to MyUNCChart* **(Will require entering 4-digit birth year)****

	Pick up in Release Dept (HIM)
	Verbal release
	Other. Specify:

***Releases to MyUNC Chart must be processed by HIM**
****Access via MyUNC Chart will only be available for 30 days; although you may print and/or save a copy for your personal use.**

I UNDERSTAND THAT:

- I may revoke this Authorization at any time:
  - The revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department.
- I may refuse to sign this Authorization:
  - My treatment, payment, enrollment in a health plan, or eligibility for benefits can not be conditioned upon my authorization of this disclosure.
  - A fee may be charged for providing the protected health information. Please contact Copy Service to obtain fee and rate information at 919-784-7379.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form.

Signature of Patient:		
Printed Name:	Date:	Time:

Or

Signature of Authorized Representative:		
Printed Name:	Date:	Time:
Please explain Representative's authority to act on the behalf of the Patient:		

OFFICE USE ONLY	
PROCESSED DATE: _____ ☐ ID Checked PROCESSED BY: _____ TOTAL PAGES: _____ ADDITIONAL NOTES:	STAMPS / ADDITIONAL NOTES: