LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

# INFECTIOUS DISEASE TROPICAL MEDICINE & TRAVEL CLINIC

**REFERRING PHYSICIAN**: _____

## DEMOGRAPHICS

| | | |
|---|---|---|
| **LAST NAME** | **FIRST NAME** | **MIDDLE INITIAL** |
| **SOCIAL SECURITY NUMBER** | **SEX** | **PREFIX/SUFFIX** |
| **DATE OF BIRTH** *(mm/dd/yy)* | **STATUS** *(please circle one)*<br>Single Married Divorced Widowed<br>Legally Separated Partner | **STUDENT** *(please circle one)*<br>No Full-Time Part-Time |
| **STREET ADDRESS** | **CITY/STATE** | **ZIP CODE** |
| **HOME PHONE** *(include area code)* | **CELL PHONE** | **WORK PHONE** |
| **RACE** *(please circle one)*<br>American Indian/Alaska Native Hawaiian/Pacific Islander<br>Black/African American Asian White Decline Response | **ETHNICITY** *(please circle one)*<br>Hispanic or Latino Not Hispanic or Latino<br>Unknown Decline Response | **PREFERRED LANGUAGE**<br>English Spanish<br>Other: _____ |
| **Gender Identity (***please circle one)*<br>Male Female Female-to-Male (FTM)Transwomen<br>Male-To-Female (MTF) Transman Genderqueer, neither<br>exclusivley Male nor Female Decline Response Other: | **EMPLOYER – JOB TITLE/ SATUS** | **EMAIL ADDRESS** |

| | | |
|---|---|---|
| **PREFERRED PHARMACY** | **PHARMACY PHONE NUMBER** | **PHARMACY ADDRESS** |

## EMERGENCY CONTACT INFORMATION

| | | | | |
|---|---|---|---|---|
| **CONTACT** *(please circle at least one)*<br>Emergency Contact Next of Kin<br>Insured Authorized to Seek Treatment | | **LAST NAME** | **FIRST NAME** | **MIDDLE INITIAL** |
| **SSN** *(social security number)* | **DATE OF BIRTH** *(mm/dd/yy)* | **RELATIONSHIP TO PATIENT** | **SEX** | **MARITAL STATUS** |
| **HOME ADDRESS** | | **CITY/STATE** | **ZIP CODE** | **HOME PHONE** |
| **EMPLOYER** | **JOB TITLE** | **CELL PHONE** | | **WORK PHONE** |

Name: _____ Date of Birth: _____

## PATIENT HISTORY

**CURRENT MEDICATIONS:** Are you taking any medications now? ◯ Yes ◯ No
If yes, please list **name** and **dosage** of the medicine. Include prescription, over the counter, natural, herbals:

| Name of Medicine(s) | Dosage(if known) | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

What is the **REASON** for today's visit? _____

**ALLERGIES**: Are you allergic to any **MEDICATIONS**? ◯ Yes ◯ No
If yes, please list the medication(s) and reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Have you **TRAVELLED OUTSIDE THE COUNTRY** recently? ◯ Yes ◯ No
If yes, please state where and when? _____ Date:_____

Did you receive any **IMMUNIZATIONS** other than **PRIMARY SERIES** (childhood vaccines)? ◯ Yes ◯ No
If yes, please list immunization(s): _____

Have you ever had a positive **TUBERCULOSIS TEST** or have had **HISTORY OF EXPOSURE**? ◯ Yes ◯ No
If yes, please explain: _____

Have you had any **BITES** or **RASHES** that required treatment by a physician? ◯ Yes ◯ No
If yes, please explain: _____

Please list all past **SURGERIES** and **HOSPITALIZATIONS** and the approximate date below:

| Surgery/Hospitalization | Date (approximate) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**PAST MEDICAL HISTORY:** Have you ever been diagnosed with any of the following? ◯ Yes ◯ No
If yes, please circle the following that apply:

| | | | |
|---|---|---|---|
| Acid Reflux | COPD | Headache | Thyroid Disorder |
| Allergic Rhinitis | Emphysema | Hearing Loss | Immunodeficiency |
| Anxiety Disorder | Depression | Hepatitis A, B or C | Sleep Apnea |
| Asthma | Deviated Septum | Herpes Zoster/Shingles | Tonsillitis |
| Bleeding Disorder | Diabetes Type I or II | High Blood Pressure | TMJ Disease |
| Cancer TYPE: | Ear Infections | High Cholesterol | Other: |
| Chronic Sinusitis | Renal Disease | HIV or AIDS | Other: |

**FAMILY HISTORY**

| | | | |
|---|---|---|---|
| Father | | ◯ Alive ◯ Deceased | ◯ Healthy ◯ Medical Problems: |
| Mother | | ◯ Alive ◯ Deceased | ◯ Healthy ◯ Medical Problems: |
| Brother (s) | # | ◯ Alive ◯ Deceased | ◯ Healthy ◯ Medical Problems: |
| Sister (s) | # | ◯ Alive ◯ Deceased | ◯ Healthy ◯ Medical Problems: |
| Son (s) | # | ◯ Alive ◯ Deceased | ◯ Healthy ◯ Medical Problems: |
| Daughter (s) | # | ◯ Alive ◯ Deceased | ◯ Healthy ◯ Medical Problems: |

**SOCIAL HISTORY**

**OCCUPATION:** What is your occupation? _____
◯ Full-time ◯ Part-time ◯ Student ◯ Unemployed ◯ Retired ◯ Other:

**PETS:** Do you have pets in the home? ◯ Yes ◯ No ◯ Dog ◯ Cat ◯ Bird ◯ Other:

**SMOKING:** Do you smoke cigarettes? ◯ Yes ◯ No #____ Packs/Day? Former Smoker? ◯ Yes ◯ No

**CHEWING TOBACCO:** Do you chew tobacco? ◯ Yes ◯ No

**ALCOHOL:** Do you consume alcohol? ◯ Yes ◯ No Drinks per Week? ◯ 2 or less ◯ 3-5 ◯ >6

**DRUGS:** Do you use any recreational drugs? ◯ Yes ◯ No Former User? ◯ Yes ◯ No List:

**HOME LIVING SITUATION:** ◯ Alone ◯ w/Spouse ◯ w/Spouse & Kids ◯ w/Kids ◯ Other:

**SEXUAL ORIENTATION:** ◯ Heterosexual ◯ Same Sex ◯ Bisexual

Name: _____ Date of Birth: _____

## PATIENT REVIEW OF SYSTEMS

Please indicate if you have any of the symptoms below, if no symptoms are present, please mark **None**:

**GENERAL**
- ◯ None
- ◯ Fever
- ◯ Chills
- ◯ Fatigue
- ◯ Weakness
- ◯ Night sweats
- ◯ Difficulty walking

**SKIN**
- ◯ None
- ◯ Rash
- ◯ Itching
- ◯ Lumps

**RESPIRATORY**
- ◯ None
- ◯ Cough
- ◯ Sputum production
- ◯ Coughing up blood
- ◯ Shortness of breath
- ◯ Wheezing

**NEUROLOGICAL**
- ◯ None
- ◯ Dizziness
- ◯ Fainting
- ◯ Seizures
- ◯ Numbness
- ◯ Tingling
- ◯ Insomnia

**PSYCHIATRIC**
- ◯ None
- ◯ Depression
- ◯ Anxiety
- ◯ High stress level
- ◯ Memory loss

**HEAD**
- ◯ None
- ◯ Headache
- ◯ Ringing in ears
- ◯ Mouth sores
- ◯ Sore throat
- ◯ Dry mouth
- ◯ Hoarseness
- ◯ Sinus pain

**EYES**
- ◯ None
- ◯ Double vision
- ◯ Loss of vision
- ◯ Red, itchy eyes

**CARDIOVASCULAR**
- ◯ None
- ◯ Chest pain
- ◯ Chest tightness
- ◯ Palpitations
- ◯ Difficulty breathing lying down
- ◯ Exercise intolerance

**HEMATOLOGIC**
- ◯ None
- ◯ Easy bruising
- ◯ Prolonged bleeding
- ◯ Coughing up blood
- ◯ Vomiting blood
- ◯ Blood in stool
- ◯ Blood in urine

**NECK**
- ◯ None
- ◯ Lumps
- ◯ Swollen lymph nodes
- ◯ Pain
- ◯ Stiffness

**MUSCULOSKELETAL**
- ◯ None
- ◯ Muscle pain
- ◯ Joint pain
- ◯ Stiffness
- ◯ Back pain
- ◯ Swelling

**ENDOCRINE**
- ◯ None
- ◯ Excessive thirst
- ◯ Frequent urination
- ◯ Heat intolerance
- ◯ Cold intolerance
- ◯ Increase in appetite
- ◯ Decrease in appetite
- ◯ Hair loss

**GENITOURINARY**
- ◯ None
- ◯ Burning while urinating
- ◯ Painful urination
- ◯ Urinary urgency
- ◯ Flank pain

**GASTROINTESTINAL**
- ◯ None
- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Constipation
- ◯ Bloating
- ◯ Swallowing difficulties
- ◯ Heartburn

## LOUDOUN MEDICAL GROUP
## Receipt of Notice of Privacy Practices Acknowledgement

I, _____, acknowledge receiving on
(print patient name)

_____, a copy of Loudoun Medical Group's Notice of Privacy Practices.
(print date)

_____
**Patient signature or initials**

---

## FOR OFFICE USE ONLY

**I attempted to obtain the patient's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:**

| Date | Staff Initials | Reason |
|---|---|---|
| | | **Refused to sign** (circle if applicable)<br><br>**Other:** |

**LOUDOUN MEDICAL GROUP / INFECTIOUS DISEASE TROPICAL MEDICINE**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

***As required by the privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.***

---

**ADDITIONAL CONTACT INFORMATION**

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following person(s), entity(s), or business associates of this office:

| Name | Phone | Relationship |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I give Dr. Sarfraz Choudhary office permission to leave my results or any pertinent medical information on my home voicemail or my cell phone. ***Please circle:*** YES or NO

My signature verifies that this request accurately reflects my wishes. I understand that this form is **valid for 1 year from the date of signature**. It is my responsibility to notify Infectious Disease of any changes prior to the expiration of this form.

_____ _____

Signature Date

I understand that I have the right to: Revoke this authorization at any time by giving written notice to the office. Inspect a copy of patient health information being used for disclosure under federal law. Refuse to sign this authorization. Receive a copy of this authorization and restrict what is disclosed with this authorization.

---

**REFUSAL TO SIGN ONLY**

*I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.*

Refusal to Sign Signature: _____ Date: _____

Witness Signature: _____ Date: _____

## CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. X _____ **(Please initial)**

## NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X_____(Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X_____(Please initial)**

## CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

**Opt In: Send and Receive Documents**
X_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

**Opt Out:** Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.
X_____

## MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- All patients were prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X _____(Please initial)**

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

_____
Relationship (if any)