South Palm Beach Health Group, PLLC.

Dr. Richard Martinoff Dr. JoAnn Yi

Your last name: ______________________ First name: ______________________

Address: ____

City: ______________________ State: __________ Zip: __________

Phone: (______) ______ - ________ Date of Birth: _____ /_____ / _____

E-mail address: ______________________ SS#: ______________________

Gender: □Male □Female

Ethnicity: □Hispanic □Non-Hispanic □Declined Primary language: ______________

Race: □Asian □African-American □Hawaiian/Pacific Islander □White □Other □Declined

Reason for your visit today: ______________________________________

Please list all medical illnesses and surgeries you've had. Include all chronic illnesses and procedures for which you have seen a doctor or have been to the Emergency Room / Hospital.

Condition	Year	Describe where. Who treated you and what happened?

Please list all medications you are currently taking. Include any over-the-counter or herbal medications.

Name of medication	Dose (usually in milligrams)	How many times do you take it? (Daily, twice a day, etc.)	What is the reason for taking this medication?

Signature: ______________________

Do you have any of the following symptoms?		
Low energy	□ Yes	□ No
Headaches	□ Yes	□ No
Vision changes	□ Yes	□ No
Hearing changes	□ Yes	□ No
Changes in sense of smell	□ Yes	□ No
Sore throat	□ Yes	□ No
Difficulty or pain with swallowing	□ Yes	□ No
Heartburn	□ Yes	□ No
Chest pain	□ Yes	□ No
Palpitations/ Irregular heart beat	□ Yes	□ No
Shortness of breath	□ Yes	□ No
Cough	□ Yes	□ No
Coughing up blood	□ Yes	□ No
Abdominal pain	□ Yes	□ No
Nausea/Vomiting	□ Yes	□ No
Diarrhea	□ Yes	□ No
Constipation	□ Yes	□ No
Blood in stool	□ Yes	□ No
Black stool	□ Yes	□ No
Pain or burning with urination	□ Yes	□ No
Frequent urination	□ Yes	□ No
Blood in urine	□ Yes	□ No
Irregular periods	□ Yes	□ No
Back pain	□ Yes	□ No
Sadness	□ Yes	□ No
Anxiety/ Nervousness	□ Yes	□ No
Difficulty sleeping	□ Yes	□ No
Weakness of legs	□ Yes	□ No
Weakness of arms	□ Yes	□ No
Joint pain	□ Yes	□ No
Difficulty walking	□ Yes	□ No

Signature: ____

<table>
<tr><td>Is your father alive?
□ Yes □ No
If so, how old is he? __________</td><td>What medical problems did he have?
□ Heart disease/Heart attacks
□ Diabetes
□ Cancer, Specify type: _____________________
Others:</td></tr>
<tr><td>Is your mother alive?
□ Yes □ No
If so, how old is she? __________</td><td>What medical problems did she have?
□ Heart disease/Heart attacks
□ Diabetes
□ Cancer, Specify type: _____________________
Others:</td></tr>
<tr><td>Please list other relatives with medical conditions.</td><td></td></tr>
</table>

<table>
<tr><td>Do you drink caffeine (coffee/tea)? If so, how many cups per day?</td><td></td></tr>
<tr><td>Do you drink alcoholic beverages (wine/liquor/beer)?
If so, how many drinks per week?</td><td></td></tr>
<tr><td>Do you smoke? if so, how many cigarettes or cigars per day?
For how many years?
If you quit, how long ago?</td><td></td></tr>
<tr><td>Do you use over-the-counter medications, herbals, or recreational drugs? If so, which ones?</td><td></td></tr>
<tr><td>What kind of work do you do?
Are you satisfied with your job?
Do you feel more stressed at work?</td><td></td></tr>
<tr><td>Do you have difficulties falling or staying asleep? If so, do you use anything to help you sleep?</td><td></td></tr>
<tr><td>Are you allergic to anything?
(medications, tape, latex, environmental)</td><td>□ Penicillin
□ Sulfa
□ Other: ___________________</td></tr>
</table>

<table>
<tr><td>For FEMALE Patients:

At what age was your first menstrual cycle?</td><td></td></tr>
<tr><td>Are your periods regular?</td><td></td></tr>
<tr><td>Are you in menopause?</td><td></td></tr>
</table>

South Palm Beach Health Group, PLLC
880 NW 13th Street, Suite 2B Boca Raton, FL 33486
Dr. Richard Martinoff Dr. JoAnn Yi
Board Certified Internal Medicine Board Certified Family Medicine

MEDICAL RECORDS RELEASE FORM

I HERBY AUTHORIZE SOUTH PALM BEACH HEALTH GROUP TO USE, DISCLOSE, OR RECEIVE THE SPECIFIC INFORMATION DESCRIBED BELOW, ONLY FOR THE PURPOSES AND PARTIES ALSO DESCRIBED BELOW.

Description of the specific information to be used or disclosed: ________________________________

____

Person, facility or physician to **RELEASE** the above information:__________________________________	Person, facility or physician to **RECEIVE** the above information: South Palm Beach Health Group Attention: Records Department 880 NW 13th Street Boca Raton, FL 33486 Fax: 561-392-1583

This information is being requested for the following purposes (i.e. changing doctors, moving, filing a lawsuit, copies for personal use, etc.):____

____

This authorization shall remain in effect from the date signed below or until _____________________________.
(expiration date or event)

I understand that:
- I may inspect the copies of the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the office at the above address, attention "Privacy Officer"
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and longer protected by HIPPA.

Patient Name:________________________________ Signature:____

Patient SS#: _________________________________ Date of Birth: ___________/__________/___________

Patient Address: ____

Relationship to patient (if signed by personal representative of patient): _________________________________

Witness: ____________________________________ Date: ____

I understand that my records may contain information pertaining to my diagnoses or treatment of medical, psychiatric, AIDS/ARC/HIV testing. I also understand that any topic discussed during my medical treatment was documented and, therefore, will be released.
I understand that this release can be revoked at any time by giving written notice.