Naveen Kumar

1616 S Apollo Blv Melbourne FL 32901

Phone 321-409-9577 Fax 321-409-9877

Dear New Patient,

We at Healthy Journeys, Inc. wish to take a moment to welcome you to our practice.

Our philosophy is to provide comprehensive medical care, while treating every patient with dignity and respect. We want to sit down and talk with patients, and provide patients with ample opportunity to discuss medical concern with us.

We see patients for many types of medical concerns. We treat a wide spectrum of both acute illnesses and chronic conditions. Preventive care is also critical for ensuring your health, and we take that very seriously. Also please do not hesitate to call us to discuss your medical needs. If you are sick we will try our best to get you in as quick as possible.

A little information about our office and our policies. If you are on any maintenance medications you are required to See the doctor every three months. All controlled Perceptions will need to be picked up at the office. **All Narcotics will need an appointment with the doctor every time they are picked up and given at the doctors discretion or sent to pain management**. All medications please allow 24 hour in advance for refills.

Copays are due at time of service

We look forward to seeing you at the clinic, and we will do our best to make your visit as pleasant, efficient, and complete as possible.

Please be courteous of other patients and be on time for your appointment, if you are late for your appointment the appointments that arrive on time will be seen before you. If you are more than 10 min late for an appointment you may be canceled.

Thank you for giving us the opportunity to serve you and your family.

Sincerely,

The Staff of Healthy Journeys, Inc.

1616 S Apollo Blvd Melbourne FL 32901

Phone 321409-9577 Fax 321-409-9577

HEALTHY JOURNEYS, INC.

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: ____________________

PATIENT DATE OF BIRTH: __________ **TODAY'S DATE:** __________

What would you like to talk to your doctor about today? ____________________

____

MEDICAL HISTORY

Please list any medication allergies or reactions:

____

____

Please check to indicate if you have ever had the following conditions:

☐ Diabetes ☐ High blood pressure ☐ Asthma ☐ Heart attack
☐ Kidney disease ☐ Hepatitis ☐ Thyroid disease
☐ Stroke ☐ Depression ☐ Emphysema ☐ Seizures
☐ Tuberculosis ☐ Coronary Artery Disease ☐ Congestive Heart Failure
☐ Arrythmia ☐ Sexually transmitted disease – type: __________
☐ Eye problems – type: __________ ☐ Cancer – type: __________
☐ Other, please explain: ____________________

Please list any surgeries or hospital stays you have had and their approximate date/year:

If additional space is need see last page .

Type of surgery / reason for hospitalization / location	*Date*

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

____

____

When was your last physical?

____

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name	*Dosage*
__________	__________
__________	__________
__________	__________
__________	__________
__________	__________

If additional space is need see last page

What pharmacy do you use for prescription medications?

____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*
__________	__________
__________	__________
__________	__________

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*
Tetanus	______	Influenza	______
Pneumonia	______	Hepatitis B	______
Other: ______	______	Other: ______	______

If you have had any of the following tests done, please note when the tests was done and what the results were, if known:

Test	*Approximate Date*	*Result*
Cholesterol	______	__________
Pap smear/pelvic	______	__________
Mammogram	______	__________
Blood in stool	______	__________
HIV	______	__________
Colonoscopy	______	__________
Hepatitis C	______	__________

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments:

____

____

____

____

HEALTH HABITS

Do you smoke or use any tobacco products?.. ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? __________

For how many years? __________________

Other forms of tobacco used? ____________

Do you drink alcohol?.. ☐ Yes ☐ No ☐ Quit

How much? ____________________

How often? ____________________

Have you ever felt that you should cut down on your drinking?................................ ☐ Yes ☐ No

Have you regularly used other drugs?... ☐ Yes ☐ No

If yes, are you still using them?.. ☐ Yes ☐ No

PERSONAL HISTORY

Are you currently married or living with a significant other?.. ☐ Yes ☐ No

Who lives with you at home?______________________

Are you employed?.. ☐ Yes ☐ No

If yes, what kind of work do you do?__________________________

If no, is this by choice?___ Disability?____ Other reasons?_____________

Do you exercise more than 2 times per week?... ☐ Yes ☐ No

Do you often feel sad or depressed?... ☐ Yes ☐ No

Do you feel there is something seriously wrong with your body?................................. ☐ Yes ☐ No

Are you having money problems which limit your access to food, shelter or medical care?......... ☐ Yes ☐ No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation?......................... ☐ Yes ☐ No

Do you have some form of church or spiritual support? .... ☐ Yes ☐ No

SEXUAL HISTORY

Are you sexually active? .... ☐ Yes ☐ No

With: ☐ Men ☐ Women ☐ Both

Do you feel you are at risk for HIV/AIDS? .... ☐ Yes ☐ No

Do you have children? .... ☐ Yes ☐ No

How many children do you have? _________

Do you use any form of birth control? .... ☐ Yes ☐ No

If yes, which type / brand? ______________________________________

WOMEN ONLY

Have you ever been pregnant? .... ☐ Yes ☐ No

How many times? ______________

How many miscarriages? ____________

How many abortions? ______________

How many children do you have living? ____________________

Do you have menstrual periods? .... ☐ Yes ☐ No

If no, at what age did they stop? _____________

If yes, are your periods regular? _____________

OTHER COMMENTS:

____

____

____

____

Safety and fall Precautions

Do you use any of the following?

- ☐ Wheelchair
- ☐ Cane
- ☐ Motorized scooter or wheelchair
- ☐ Oxygen
- ☐ Cpap Machine
- ☐ Hospital bed
- ☐ Shower seat

Does your home have the following?

- ☐ Bed rails
- ☐ Shower rails
- ☐ Stairs rails
- ☐ Grab bars (bathroom)

Do you have any of the following? (If you have any of the following please bring a copy with you)

- ☐ DNR
- ☐ Living will
- ☐ Advance directive

Additional medication sheet

Medication Name	Dosage

Additional Surgeries space

Type of surgery /location	Date

Patient Information~ Healthy Journeys Inc.

First Name	Middle Name	Last Name
SS Number	**Date of Birth**	**Age**
Gender	**Marital Status**	**Children**
Male or Female		
Address		
City	**State**	**Zip**
Home Phone	**Cell Phone**	**Race**
Email	**Emergency Contact**	**Emergency Contact Phone**
Work Status	**Work Phone**	**Company Name**
Address		

Responsible Party

Self?	Yes or No	(If no, please provide details below)

Relationship to Patient		
First Name	**Middle Name**	**Last Name**
Address		
City	**State**	**Zip**
Home Phone	**Other Phone**	

HEALTHY JOURNEYS, INC.

HEALTH INFORMATION RELEASE FORM

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to *Healthy Journeys*. I understand that revocation will not apply to information that has already been released in response to this authorization.

In order to assist you in receiving your health information from *Healthy Journeys*, please complete this form.

I authorize the persons listed below to have access to any and all my health information, including HIV,drug and alcohol abuse, and psychiatric records. *Healthy Journeys* is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons Authorized to receive my medical information (full name and phone number):

You may notify me or the parties listed above with the test results, appointment reminders and any other information regarding my health as follows:

____ Message on answering machine Phone number ____________

____ Message on work voice mail Phone number____________

____Message on pager Phone number ____________

____Message on cell phone Phone number ____________

____ Other________________________

I understand and direct that this authorization will remain in effect until revoked by me in writing.

Patient- Print Name **Date:** **Witness- Print Name**

Patient-Signature **Date:** **Witness-Signature**

Patient- Date of Birth **Patient Account #**

HEALTHY JOURNEYS, INC.
Naveen Kumar, MD
1616 S. Apollo Blvd, Melbourne, FL 3290 Phone 321-409-9577 Fax 321-409-9877

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: HEALTHY JOURNEYS, INC.

Address: Naveen Kumar, M.D.
1616 S. Apollo Blvd

City: Melbourne, FL 32901 State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.