Drexel Medicine

Welcome to Drexel Medicine!

Thank you for choosing Drexel Medicine for your health care. We pride ourselves on providing quality, compassionate care to promote optimal health and well-being. During your visit, our physicians and staff strive to provide you with the best possible experience. To assist us, we ask that you complete the attached forms and bring them with you on the day of your appointment. We have also included helpful information about our office, referrals, and medication refills.

Please bring the following to your first appointment:

___ Insurance card, valid ID and co-pay (if you have one). For all HMO patients, please check that our office is listed as the primary. If not, please call your insurance company to have it changed.

___ Completed Patient Health History Form

___ Consent to Shared Electronic Medical Record for Medical Care

___Patient Portal Consent (optional, but encouraged)

___Bring your medications, supplements and any over-the-counter medications

Please complete all of your forms and plan to arrive 20 minutes prior to your appointment time to allow for registration. If you did not complete the health history, please arrive 30 minutes prior to your appointment.

We look forward to your visit and the opportunity to provide your health care. If you have any questions or concerns, please call your physician's office. Directions for all of our office locations can be found on our web site at drexelmedicine.org.

<u>Our Contact Information</u>

Drexel Internal Medicine at 219 N. Broad Street, 6th Floor– Phone: 215.762.5037
Drexel Internal Medicine at 205 N. Broad Street, 1st Floor– Phone: 215.587.8008
Drexel Internal Medicine at Rittenhouse Square, 255 S. 17th Street – Phone: 215.735.8504
Drexel Medicine at Fairmount, 2126 Fairmount Ave – Phone: 215.236.4600
Drexel Center for Women's Health, 219 N. Broad Street, 6th Floor – Phone: 215.762.5181
Drexel Internal Medicine's Ambulatory Practice at 1427 Vine St- Phone: 215.762.6565

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____ **Age:** _____ **Gender:**_____
Marital Status: __ **Single** __ **Married** __ **Other**

Reason for visit: □ **Annual Exam** □ **Problem(s)**

Please give brief description of problem(s):

Do you have any known allergies: □ **No** □ **Yes, please list allergy**

Please list all medical conditions:

Please list any past surgeries and year:

Are you presently taking any medication(s)? If yes, please list medication below:

Medication Name	Dose	Frequency	For what illness?

Have you been admitted to a hospital during the past 5 years? Yes or No. If yes, please list the name of the hospital, date(s) of admission and reason.

Date(s)	Name of Hospital	Reason for Admission

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____

Please answer the following questions by checking YES or NO.

Yes	No		
		Do you currently smoke cigarettes?	If yes, packs per day: Years of use:
		Other tobacco products	How often:
		What type:	Years of use:
		Did you quit smoking?	If yes, how long ago?
		Do you drink alcohol?	If yes, how many drinks per week?
		Do you use recreational drugs?	If yes, please list:
		Are you sexually active?	□ Men □ Women □ Both
		How many partners in lifetime?	
		History of sexually transmitted disease?	
		Have you ever been abused?	□ No □ Yes
			□ Physically □ Sexually □Emotionally

If any of your family members (parents, siblings, children) have been diagnosed with the following condition(s), please indicate by completing the following:

Yes	No	Medical Condition	If YES, please indicate family member
		Breast Cancer	
		Colon Cancer	
		Uterine or Ovarian Cancer	
		Other Cancer	
		Heart Disease	
		High Blood Pressure	
		Asthma	
		Tuberculosis	
		Lung Disease	
		Diabetes	
		Anemia	
		Hepatitis	
		Arthritis	
		Kidney Disease	
		Stroke	
		Birth Defect	
		Osteoporosis	
		Glaucoma	
		Mental Condition	
		Drug or Alcohol Addiction	
		Hereditary Disease (please specify)	
		Other (please specify)	

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____

Review of Symptoms

Please fill out this section carefully. The doctor will review the form and ask you about any **"YES"** responses during the course of your visit. Please be assured that this information is strictly confidential.

Do you have any current or recent health problems? Check YES or NO in the column before each problem.

Yes	No	Constitutional	Yes	No	Gastrointestinal	Yes	No	Neurological
		Weight change			Indigestion/Heartburn			Headache/Migraine
		Appetite change			Stomach/abdominal pain			Vertigo
		Fever			Constipation			Disorientation
		Excessive fatigue			Diarrhea			Fainting/blackout spells
		Night sweats			Change in bowel habits			Seizures
					Rectal bleeding			Numbness, tingling
		Eyes			Polyps			Weakness
		Blurred vision			Hemorrhoids			Coordination problems
		Redness/Discharge			Nausea/Vomiting			Memory Loss
		Double vision			Decreased appetite			Tremors
		Light sensitivity			Belching/Bloating			
								Psychiatric
		Ears/Nose/Throat			**Genitourinary**			Anxiety
		Hearing loss			Pain/burning w/urination			Depression
		Hearing aid			Blood in urine			Panic attacks
		Pressure or ringing in ears			Difficulty urinating			Difficulty concentrating
		Pain in ear			Incontinence			Mood Swings
		Dizziness			Vaginal/Penile discharge			
		Nasal congestion			Erectile dysfunction			**Endocrine**
		Runny nose			Pain during intercourse			Diabetes
		Nosebleeds			Frequent urination			Hormone problems
		Tooth/Gum bleeding			Frequent UTI			Low blood sugar
		Sore throat						Thyroid disease
		Difficulty swallowing			**Musculoskeletal**			Excessive thirst
		Change in taste			Joint pain or swelling			Excessive urination
		Hoarseness			Stiffness			Pituitary gland problems
					Difficulty walking			Excessive/night sweating
		Cardiovascular			Muscle twitching or pain			
		Chest pain						**Hematologic**
		Arm and leg swelling			**Integumentary/Skin**			Easy bleeding/bruising
		Palpitations			Itching			Swollen glands
		Leg pain			Rash			
					Dry Skin			**Immunologic**
		Respiratory			Changes in skin color			Hay fever
		Exercise induced cough			Changes in moles			Food allergies
		Shortness of breath			Excessive sweating			Immune system problems
		Cough			Breast pain or swelling			Connective tissue disease
		Wheezing			Ulcers			Frequent colds/infection
		Blood in sputum						Environmental allergies
		Oxygen use at home						

New Patient History Questionnaire

Name_____ Appointment Date: _____

Birthdate: ____/_____/_____

Please answer the following questions by checking YES or NO.

Yes	No	Immunization	If YES, please indicate month/year
		Flu Shot for this year	When:
		Tetanus	When:
		Pneumonia	When:
		Hepatitis B	When:
		Rubella	When
		Hepatitis A	When:
		Varicella (Chicken Pox)	When:
		History of Chicken Pox	When:
		Tested for Tuberculosis (PPD or tine)	When: Positive: Y or N
		Tuberculosis Exposure?	
		Other	

Please provide the name of your primary care doctor:

Name: _____

Address: _____Phone Number: _____

If you have other doctors who are involved with your care please provide information below*:

Name	Specialty:

*If you have multiple medical conditions, please include the names of each doctor involved in your care

I understand the above information is necessary to provide me with surgical/medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

Patient/Guardian Signature:_____ Date:_____

I have reviewed the form and discussed it with the patient.

Attending Physician Signature:_____ Date:_____

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____

Screening (please supply month and year if applicable)

Yes	No	Screening Test	If yes, when?
		Last Physical Exam	
		Colonoscopy	
		Flexible Sigmoidoscopy	
		Stool Cards (to evaluate for colon cancer)	
		PSA Testing (prostate cancer screening)	
		Cholesterol Level	
		Digital Rectal Exam	
		Bone Density	

Please answer the following questions by checking YES or NO.

Yes	No		
		Do you drink coffee or tea?	
		Do you exercise?	If yes, times per week? Duration:
		Do you follow a particular diet?	If yes, which kind?
		What is your occupation?	
		Do you have children?	If yes, how many?
		Do you wear a seatbelt?	
		Do you wear a bike helmet?	
		Do you use sunscreen?	
		Is there a gun in your home and is it out of children's reach and unloaded?	
		Have you ever worked with Chemicals, paints, asbestos or other hazardous materials?	
		Do you have a living will?	If yes, did you bring a copy with you?
		Do you have a donor card?	
		Are you currently pregnant?	□ No □ Yes
			If yes, # of months:
		Are you nursing?	□ No □ Yes

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____

Woman's Health History

Menstrual History

Age of first period:	
How frequent are periods?	
Flow is	□ Light □ Average □ Heavy
How many days?	
Do you have any symptoms associated with periods?	
When was first day of last period?	
Are you menopausal?	□ No □ Yes If yes at what age:
Do you having any premenopausal symptoms? (Specify)?	
Have you ever been on hormone therapy?	At what age:
What medications and when?	

PAP History

Date of last PAP:	Date: □ Never had a PAP
Have ever had an abnormal PAP?	□ No □ Yes
What was diagnosis?	
What was treatment?	
Have ever had a sexually transmitted infection(s)?	□ No □ Yes
If yes what infection and when?	

Breast History

When was your last mammogram:	Date: □ Never had mammogram
Have you ever had an abnormal mammogram?	□ No □ Yes If yes, when:
What was the finding:	
Do you have any breast discharge?	□ No □ Yes
Have you ever had a breast biopsy?	□ No □ Yes If yes, when:
What was diagnosis?	
What was treatment?	
Do you do monthly self-breast exams?	□ Yes □ No

New Patient History Questionnaire

Name_____ Appointment Date: _____

Birthdate: ____/_____/_____

Obstetric History

Have you ever been pregnant?	□ No □ Yes If yes answer all questions
How many pregnancies?	
How many babies did you deliver?	
Have you ever had a miscarriage?	□ No □ Yes If yes how many:
Have you ever had an abortion?	□ No □ Yes If yes how many:
Have you ever had a tubal/ectopic pregnancy?	□ No □ Yes If yes how many:
Have you ever had any premature births?	□ No □ Yes If yes how many:

Child Birth History

#	Sex of Baby	Year of Birth	Weeks Pregnant	Weight of Baby	Vaginal or C-Section	Complications

I have reviewed the above information and discussed all pertinent findings with the patient.

_____ _____

Attending Signature ***Date***

DREXEL UNIVERSITY
FOR ITS COLLEGE OF MEDICINE

CONSENT TO SHARED ELECTRONIC MEDICAL RECORD FOR MEDICAL CARE

The Drexel University Physicians® (DUP) clinical groups have put into place a shared Electronic Medical Record (EMR). This means that patients' medical history, diagnosis and treatment records will be placed and stored on a computer system. The shared Electronic Medical Record (EMR) will enable our physicians, staff and students to build and maintain a shared medical record that helps in providing well-coordinated clinical care from a shared, multidisciplinary understanding of each patient's medical history, current problems and ongoing treatment.

The right to view and use the electronic medical record for clinical care is provided to physicians, staff, medical students, and residents/fellows (physicians in training) of Drexel University for its College of Medicine, parties to our Organized Health Care Arrangement (OHCA) and affiliated practitioners who use the shared Electronic Medical Record (EMR) and those who may be connected through a developing computer system called a Health Information Exchange (HIE), third party payers who are given this right according to their duties and to others as explained in our Notice of Privacy Practices. Such information exchange is for purposes of providing continuity of care.

DIRECTED EXCHANGE FOR TREATMENT: Additionally our EMR also permits your doctor to **send** and **receive** health care information to improve coordination of care, such as medication history, information for treatment and additional health information for when he or she refers you to another doctor, or health care entity involved in your care. This is referred to as **Directed Exchange for Treatment**.
If your medical record includes **Highly Confidential Information** (such as mental health diagnoses and treatment, HIV/AIDS-related diagnosis and treatment, drug and alcohol abuse treatment, sexual assault counseling, genetic testing results, family planning related issues and the diagnosis and treatment of sexually transmitted diseases), both federal and state laws require a separate consent to share such **Highly Confidential Information**. This consent is presented for this purpose. Access to the EMR will be tracked and audited by Drexel University's Chief Privacy Officer.

This consent is provided to confirm that you understand how the EMR System works and to get your permission to include your medical information, including the **Highly Confidential Information, so that you can receive the benefits of integrated care.** Integrated medical record systems have been shown to decrease the risk of adverse drug interactions, reduce medical errors and provide for better health outcomes.

In addition to members of the health care team, we may exchange requested information with those responsible for paying for your medical care, such as your health insurance plan. Any additional uses and disclosures will be in accordance with federal and state laws and our Notice of Privacy Practices, as has been done with your paper medical record.

Please be aware that consent is not required for the group practice to electronically store and use certain information within the health system, such as laboratory test results and medical record information which is needed for billing purposes.

I hereby consent to: Drexel University Physicians (DUP) clinical practices entering my medical record information into the shared Electronic Medical Record System including **Highly Confidential Information** which may include mental health diagnoses and treatment, HIV/AIDS-related diagnoses and treatment, drug and alcohol abuse treatment, sexual assault counseling, genetic testing results, family planning related issues and the diagnosis and treatment of sexually transmitted diseases.

Patient Name (Printed) MRN

DREXEL UNIVERSITY
FOR ITS COLLEGE OF MEDICINE

CONSENT TO SHARED ELECTRONIC MEDICAL RECORD FOR MEDICAL CARE

For the purpose of: Medical care provided by Drexel University Physicians, affiliated practitioners, parties to our OHCA and other healthcare computer systems, such as those for sending and receiving electronic prescriptions, medication history.

For the following dates of service: This consent will begin on the date of my signature below and include all record of my care currently on file. This consent will continue in effect until I revoke it.

Revocation: I have been informed and understand that this consent, except for action already taken, may be revoked by me in writing at any time, but that any medical information shared in the Electronic Medical Record before I revoke may not be able to be withdrawn from the Electronic Medical Record.

This consent is effective on the date of signature below and has been fully explained to me, and my signature certifies that I understand its content.

_____ _____
Printed name of Patient Date of Birth

_____
Signature of Patient Date

_____
*Printed name of Legal Guardian/Parent/Authorized Representative Date
(*Where required. Minors can sign this consent without Parent or Guardian where the law provides that minors can consent to their own medical treatment.)

_____
*Signature of Legal Guardian/ Parent/ Authorized Representative Date

_____
Printed name of Practice Representative** Date

_____
Signature of Practice Representative as Witness Date

If a patient provides ORAL CONSENT, a second witness is necessary.

_____
Printed name of Second Practice Representative** as Witness Date

_____
Signature of Second Practice Representative as Witness Date

**Practice Representative must be an individual within the Drexel University Physicians® clinical group who is in some measure responsible for care of the Patient.

Copy provided to patient: **Yes / No / Patient declined copy**

This is not an Authorization Form for disclosure to third parties. This is not a waiver of any privileges or protections provided under law.

The form complies with applicable Federal and Pennsylvania state law. See Notice of Privacy Practices for further details about our Privacy Practices.

Drexel Medicine

myHealth *at* Drexel Medicine Portal and Email Consent Form

myHealth *at* Drexel Medicine Patient Portal

Drexel Medicine has partnered with Allscripts Healthcare to provide you with access to the patient portal site, '**myHealth *at* Drexel Medicine**'. This site, a part of the Follow MyHealth application, will give you secure access to view your medical record and communicate with your provider/office staff through secure messaging.

A portal account can be a valuable tool in managing your healthcare. In order to manage this tool and keep your information safe and secure, we have instituted certain policies surrounding your participation. These details are listed below. Please review each one before signing this consent form. Your participation is completely voluntary. Your health information will not be set up to the portal without your consent.

Policies and Limitations

Appropriate Use

- The myHealth *at* Drexel Medicine patient portal is not a replacement for in-person health care. It is not appropriate to use this portal for emergency diagnosis or treatment. In all emergency situations, seek immediate medical care or call 911.
- Internet based consults or treatments are not available through the portal. Diagnosis and treatment can only occur by scheduling an office visit with your provider.
- Drexel Medicine or Allscripts Healthcare, the vendor hosting the Follow myHealth application, may disable patient portal offerings, suspend user access or modify services offered through the portal if abusive or negligent usage is suspected.

Enrollment and Access

- You must be 18 years or older with at least one visit with a participating Drexel Medicine provider to be eligible to sign up for a portal account. Patients must start the portal sign in process in-person at their Drexel Medicine provider's office.
- During the registration process, you will be asked to review the Allscripts Follow MyHealth Terms of Use, Privacy Policy and Authorization Release of Information. Please review each document thoroughly before accepting and completing the process. For questions regarding Terms of use, contact customersupport@followmyhealth.com, for privacy questions contact privacy@followmyhealth.com
- Patients may designate another adult, over 18 years old, to have access to their portal account. An invitation to start this access must be sent by the patient from their portal account. The provider's office does not participate in this process. Please note that this sharing of portal access is referred to as "Proxy" in the portal. Directions are available in the support documents within the portal or in the FAQ's on the www.drexelmedicine.edu website.
- If at any time you wish to cancel your enrollment in myHealth *at* Drexel Medicine, you may retain your Follow myHealth account and just cancel the connection to Drexel Medicine or you can delete your FMH account in its entirety. You can make these selections from your portal account. Directions are listed in the support documentation.

Emails and Secure Messaging

- Since your email address will be used to send your portal registration invitation and health record update notifications, you are agreeing to accept email from myHealth *at* Drexel Medicine, Follow MyHealth and Drexel Medicine.edu. You may also receive emails from us regarding portal customer service surveys/feedback.
- In order to be certain that the invitation and update messages are delivered to the correct recipient, you must ensure that Drexel Medicine has your current/updated email on file at all times. Remember: Anyone with shared access to the email address you provide will also have access to your portal notifications.
- Secure messaging is a service available only from within the portal. This allows you to send different types of messages to your provider. These non-urgent messages will be reviewed during routine office hours Monday through Friday. Responses can be expected within 48 business hours.

Drexel Medicine

Questions and Support

- For questions regarding your specific health information, please contact your provider's office.
- For questions related to the functionality within the portal, please refer to the user manual located under the Support tab on your portal account home page.
- For questions related to technical support, please email the Drexel Medicine Portal Support Team at myHealth@drexelmed.edu.

Portal Consent

☐ I consent to enroll in "myHealth *at* Drexel Medicine" patient portal provided through partnership with the vendor Allscripts Healthcare using the Follow myHealth application. I understand that access to this secure patient portal is voluntary. I acknowledge that I have read and fully understand this consent form. I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose. It is my responsibility to notify Drexel Medicine if there is a change in my email account.

☐ I decline to participate in the portal at this time.

Patient Name (please print)	Email Address
Signature of patient or patient's legal authorized representative	Date
Printed name of authorized representative	Relationship to patient
Office Staff Witness Name	Date

Copy provided to patient: **Yes / No / Patient declined copy**

Drexel Medicine Primary Care
Patient Information
drexelmedicine.org

Arrival Time

If you are a new patient, please arrive approximately 20 minutes early for your first appointment (or 30 minutes early, if you did not complete your health history form). For return visits, please arrive at least 10 minutes early so that the medical staff can verify and update all of your information. You must bring a current insurance card to each appointment and a valid picture ID. Also, please bring all medications (prescribed and over-the-counter medications and supplements) to the appointment.

Lateness

You may be asked to reschedule if you are more than 15 minutes late for your appointment time. If our office can still see you, it will be after patients who arrived on time or when the physician can accommodate you.

Missed Appointments

Please call our office 24 hours in advance (or as early as possible) if you need to reschedule or cancel an appointment. Patients who fail to come for their appointments three times may be asked to leave the practice.

Response to Patient Telephone Calls/Contact Information and After Hours

Drexel Medicine responds to patient phone calls in a timely manner, in accordance with the urgency of the situation. All calls that can't be handled by medical support staff will be referred to the patient's primary care physician or another provider, depending on urgency and provider availability. For urgent matters after office hours, please call the office of your primary care physician and an on-call provider will call you back. For all medical emergencies please call 911.

Drexel Internal Medicine at 219 N. Broad Street – 215.762.5037
Drexel Internal Medicine at 205 N. Broad Street – 215.587.8008
Drexel Internal Medicine at Rittenhouse Square (255 S. 17th Street) – 215.735.8504
Drexel Medicine at Fairmount (2126 Fairmount Ave) – 215.236.4600
Drexel Center for Women's Health (219 N. Broad Street) – 215.762.5181
Drexel Internal Medicine Ambulatory Practice (1427 Vine Street)- 215.762.6565

Referrals

If you are enrolled in a managed care insurance (HMO), a referral is required for payment for all specialist visits and some diagnostic testing (ex: x-ray, ultrasounds, colonoscopy, diagnostic mammograms etc.). Referrals will be generated by the front desk staff. Physicians will provide you with a prescription for referrals. A yearly exam is required to continue receiving services including referrals from our office.

To obtain a referral by phone, please call your primary care physician's office, press the appropriate prompt and leave the following information:

1. **Your first and last name**
2. **Date of birth**
3. **Name of your insurance and ID number**
4. **Name of your physician**
5. **Best phone number to reach you**
6. **Name of specialist or facility you are scheduled for and their NPI (National Provider ID)**
7. **Reason for the visit**

IMPORTANT TO NOTE: All phone requests for referrals require (3) business days to process. You will not be able to receive a referral on the same day. You may have to reschedule your specialist appointment if you do not request a referral in advance.

Prescriptions

To obtain a prescription refill by phone, please call your primary care physician's office, press the appropriate prompt and leave the following information:

1. **First and last name, date of birth, best number to contact you**
2. **Name of your physician**
3. **Let us know if you want retail or mail order pharmacy (this does not apply to controlled substance or pain medications)**
4. **Pharmacy name and number**
5. **Name of the specific medication(s) that need to be refilled. "All medications need to be refilled or my blood pressure medicine" is not specific, and this will delay your renewals. Please have information ready to ensure proper processing time.**

All refills take up to 72 hours (3 business days) to process. Please do not wait until you are out of your medication to call for refills. Before calling in to the office for refills, please check with your pharmacy to ensure that you do not have any more refills left. **Medications requiring prior authorization can take up to 5 business days to process**. Please allow for this time and we will notify you once complete. Your provider will require you to be seen within the recommended timeframe before your medications can be renewed. Please be aware refills will only be given for prescriptions originally prescribed by our physicians.

Controlled Substances and Pain Medications

Many physicians do not write prescriptions for controlled substances and pain medications. They may refer you to the appropriate specialist to receive medication and refills.

All requests for controlled substances and pain medications are reviewed by your physician. If you run out of your medication before it is time to refill, you will **not** be given a refill until the scheduled time.

The office will contact you when your prescription is complete and ready to be picked up. Coming into the office without any notice will not guarantee that you will receive your prescription. All controlled substance prescriptions must be picked up in person with a photo ID. Patients of the Drexel Ambulatory Practice at Vine Street will only be issued their prescriptions/refills for controlled substances during their office visit.

Cell Phones

The use of cell phones is not permitted in our office. When you arrive, please silence your cell phone. If you need to make or receive a call, please step out of the office.

Payments, Outstanding Balances, and Billing

Insurance co-payment is due and payable at the time of service for the scheduled visit. If there is an outstanding balance posted on a patient's account, this will be addressed at the time of service. For billing questions, please contact our billing office at 215.246.5437.

Guidelines for Forms

Our offices charge a fee for completion of forms and placement of PPD's (when not part of an office visit). Possible forms are Financial Hardship, Utilities, Penn Dot Forms, patient assessment, FMLA, disability, etc.

Forms may take up to 5-7 business days for completion.

Cost – 2 pages or less will be $10 per form (cash only)

3 or more pages will be $20 per form (cash only)

PPD (placement, reading and completion of form) $29 (cash, credit card, or check)

Fragrance -Free

Drexel Medicine offices are committed to providing a fragrance-free environment. Fragrances are defined as any product that produces a scent strong enough to be perceptible by others, including but not limited to cologne, after shave lotion, perfume, perfumed hand lotion, fragranced hair products, scented oils, and/or similar products.