



PLEASE READ THE FOLLOWING ITEMS BEFORE FILLING OUT THIS FORM TO ENSURE ACCURACY:

- ✓ Please make sure that this medical history is complete and accurate. The information you put in this form will be released to designated health care providers when requested in a medical situation. All information provided to **CallMD** is PRIVATE and CONFIDENTIAL.
- ✓ Please print all your entries.
- ✓ Please do not leave any question blank — even if your answer is “No” or “I don’t know”.
- ✓ If you are not sure about an answer or do not have the medical information you need, please consult your physician.
- ✓ If you are including additional pages of information, such as Lab or EKG results, Discharge Summary or Living Will, and to make us sure that we received them, please indicate the number of pages: ____
- ✓ Please read carefully and sign the **CallMD** AUTHORIZATION TO RELEASE PATIENT INFORMATION at the end of this document. A parent or guardian must sign if the applicant is under the age of 18.
- ✓ Place the completed **CallMD** medical history and any additional pages of information into an envelope and mail to:

2601 Network Blvd., Suite 101, Frisco, Texas 75034

- ✓ If you are unsure about any of the questions OR need assistance in filling-out this form, please call **CallMD** at ☎ **1-866-568-6720**, between 8:30a and 4:30p CST, Monday through Friday.
- ✓ For quicker service, you may fax your medical history documents to **1-214-619-0456**.
- ✓ Your medical history will be processed within 24 hours of receipt.

NAME

DATE OF BIRTH

FIRST NAME	MI	LAST NAME	MM	DD	YYYY
EMAIL ADDRESS			CONFIRM - EMAIL ADDRESS		

PRIMARY HOME ADDRESS

APT/SUITE NO & STREET NAME		CITY			
STATE	ZIP CODE	TELEPHONE NO - <u>HOME</u>		TELEPHONE NO - <u>WORK</u>	



MEDICAL HISTORY

Your name _____

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SECONDARY HOME ADDRESS

APT/SUITE NO & STREET NAME		CITY	
STATE	ZIP CODE	TELEPHONE NO - <u>HOME</u>	TELEPHONE NO - <u>WORK</u>

PRIMARY EMPLOYER/BENEFITS PROVIDER

NAME OF EMPLOYER/BENEFITS PROVIDER		POLICY/GROUP NO	ID NO
TELEPHONE NO	ADDRESS		

SECONDARY EMPLOYER/BENEFITS PROVIDER

NAME OF EMPLOYER/BENEFITS PROVIDER		POLICY/GROUP NO	ID NO
TELEPHONE NO	ADDRESS		

EMERGENCY CONTACTS

NEXT OF KIN (NAME)		RELATIONSHIP*
TELEPHONE NO - <u>HOME</u>	<u>CELL PHONE</u> OR TELEPHONE NO AT <u>WORK</u>	IS YOUR NEXT OF KIN AN EMERGENCY CONTACT: (Y/N)

OTHER EMERGENCY CONTACT (NAME)		RELATIONSHIP*
TELEPHONE NO - <u>HOME</u>	<u>CELL PHONE</u> OR TELEPHONE NO AT <u>WORK</u>	

OTHER EMERGENCY CONTACT (NAME)		RELATIONSHIP*
TELEPHONE NO - <u>HOME</u>	<u>CELL PHONE</u> OR TELEPHONE NO AT <u>WORK</u>	

*SPOUSE / ADULT SON OR DAUGHTER / MOTHER / FATHER / ADULT BROTHER OR SISTER / OTHER: PLEASE SPECIFY



MEDICAL HISTORY

Your name _____

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PHYSICAL CHARACTERISTICS

GENDER (F/M)	HEIGHT (FT" IN')	WEIGHT (LBS)	EYES (COLOR*)	GLASSES OR CONTACTS (YES/NO)	HEARING AID (YES/NO)	DENTURES (YES/NO)	SMOKE CIGARETTES (YES/NO)	SMOKE CIGARS OR PIPES (YES/NO)

*BLUE / BROWN / GREEN / GRAY / HAZEL

LANGUAGE(S) SPOKEN

ENGLISH (YES/NO)	SPANISH (YES/NO)	CHINESE (YES/NO)	FRENCH (YES/NO)	GERMAN (YES/NO)	PORTUGUESE (YES/NO)	RUSSIAN (YES/NO)	ITALIAN (YES/NO)	OTHER

IDENTIFYING INFORMATION

DISTINGUISHING MARKS, TATTOOS OR SCARS. DESCRIBE TYPE AND LOCATION	
MOTHER'S MAIDEN NAME	PLEASE PROVIDE 4-DIGIT* PIN (PERSONAL IDENTIFICATION NUMBER)

*NUMBERS AND/OR LETTERS (UPPER OR LOWER)

IDENTIFYING INFORMATION

DISTINGUISHING MARKS, TATTOOS OR SCARS. DESCRIBE TYPE AND LOCATION	
MOTHER'S MAIDEN NAME	PLEASE PROVIDE 4-DIGIT* PIN (PERSONAL IDENTIFICATION NUMBER)

*NUMBERS AND/OR LETTERS (UPPER OR LOWER)

BLOOD TYPE

O+ (Y/N)	O- (Y/N)	A+ (Y/N)	A- (Y/N)	B+ (Y/N)	B- (Y/N)	AB+ (Y/N)	AB- (Y/N)	DON'T KNOW (Y/N)

ALLERGIES

I HAVE ALLERGIES: (Y/N)	IF YOU HAVE ALLERGIES, PLEASE COMPLETE THE FOLLOWING:		
MEDICATION		REACTION	
MEDICATION		REACTION	
BEE STINGS (Y/N)		REACTION	
X-RAY DYE (Y/N)		REACTION	



Your name _____

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ALLERGIES

OTHER		REACTION	
OTHER		REACTION	

PERSONAL PHYSICIANS

PRIMARY: NAME		SPECIALTY*	
TELEPHONE NO	ADDRESS		
SECONDARY: NAME		SPECIALTY*	
TELEPHONE NO	ADDRESS		

*ALLERGIST/CARDIOLOGIST/DERMATOLOGIST/OB-GYB/OPHTHALMOLOGIST/ORTHOPEDIST/PODIATRIST/INTERNIST/OTHER: PLEASE SPECIFY

PHARMACIES

PRIMARY: NAME	TELEPHONE NO
SECONDARY: NAME	TELEPHONE NO

SURGERY / MEDICAL PROCEDURES — If you have had surgery or a medical procedure, please complete the following ...

Surgery / Medical Procedure	Total number of times and how often?	Details



MEDICAL HISTORY

Your name _____

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PLEASE FILL-UP THE YEAR YOU HAD THE FOLLOWING MEDICAL CONDITIONS:

KIDNEY/URINARY TRACT	YEAR	ENT (EAR/NOSE/THROAT)	YEAR	HEART	YEAR
Hemodialysis		Hearing Impairment/ Deafness		Angina/Chest Pain	
Incontinence		Nasal Polyps		Arrhythmia/Palpitations	
Kidney Stones		Sinus Problems (Sinusitis)		Atrial Fibrillations	
Polycystic Kidney Disease		Seasonal Rhinitis/Allergies		Coronary Artery Disease	
Pyelonephritis		Other		Congenital Heart Disease Specify type:	
Recurrent Urinary Track Infection		EYES	YEAR	Congestive Heart Failure	
Renal Failure		Astigmatism		Cholesterol Abnormality	
Other		Blindness		Endocarditis	
REPRODUCTIVE SYSTEM	YEAR	Cataracts		Fainting (Syncope)	
Ectopic Pregnancy		Glaucoma		High Blood Pressure (Hypertension)	
Enlarged Prostate (BPH)		Macular Degeneration		Mitral Valve Prolapse	
Epididymitis		Other Retina Problems		Pericarditis	
Prostitis		Other		Valvular Heart Disease Specify Type:	
Uterine Fibroids		SKIN	YEAR	Other	
Other		Basal Cell Carcinoma		VASCULAR	YEAR
LUNGS	YEAR	Chronic Skin Ulceration		Abdominal Aortic Aneurysm	
Asthma		Dermatitis		Cerebral Aneurysm	
Chronic Bronchitis		Edema/Swelling		Peripheral Vascular Disease/ Claudication	
Emphysema		Eczema		Varicose Veins	
Pneumonia		Malignant Melanoma		Other	
Tuberculosis		Psoriasis		GLANDS/ENDOCRINE SYSTEM	YEAR
Other		Rosacea		Adrenal Insufficiency/ Addison's Disease	
		Vitiligo		Diabetes	
		Other		Thyroid Disease	
				Other	



MEDICAL HISTORY

Your name _____

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PLEASE FILL-UP THE YEAR YOU HAD THE FOLLOWING MEDICAL CONDITIONS:

BONES/JOINTS/MUSCLES (RHEUMATOLOGY)	YEAR	BLOOD /CANCER	YEAR	NEUROLOGIC	YEAR
Arthritis		Anemia		Alzheimer's Disease	
Back/Spine Problems Location:		Cancer Specify type, e.g. breast, lung, colon, prostate, uterine, etc.		Carotid Artery Disease	
Collagen Vascular Disease (e.g. Lupus, Scleroderma, etc)				Cerebral Palsy	
Fibromyalgia		Hemophilia / other bleeding disorder		Cluster Headaches	
Muscular Dystrophy		Leukemia		Meniere's Disease	
Myasthenia Gravis		Lymphoma		Migraine Headaches	
Sciatica		Multiple Myeloma		Multiple Sclerosis	
Tendonitis/Bursitis		Sickle Cell Disease		Parkinson's Disease	
Other		Thalassemia		Seizures/Epilepsy	
GASTROINTESTINAL TRACT	YEAR	Other		Stroke	
Cirrhosis		MISCELLANEOUS	YEAR	Vertigo/Chronic Dizziness	
Gall Bladder Disease				Other	
Hiatal Hernia/Reflux					
Hepatitis					
Hernia					
Inflammatory Bowel Disease					
Irritable Bowel syndrome					
Pancreatitis					
Peptic Ulcer Disease					
Other					



Your name _____

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FAMILY HISTORY

1. For each of the conditions listed, place an “X” in the box for each family member with a history of that condition.
2. If there is no history of any of the conditions for a listed family member, place an “X” in the “No History” box for that relative.
3. If you don’t know the medical history of a family member, place an “X” in the “History Unknown” box for that relative.

	FATHER	MOTHER	SIBLING	GRANDPARENT	OTHER BLOOD RELATIVE
No History					
History Unknown					
Anemia					
Congestive Heart Failure					
Coronary Artery Disease					
Angina					
High Blood Pressure					
Diabetes					
Asthma					
Epilepsy/Seizure					
Mental Illness					
Glaucoma					
Ulcer					
Cancer (specify)					
Cancer (specify)					
Other (specify)					
Other (specify)					

MEDICATIONS — If you are currently taking medications . . .

Medication	Dosage (mg., mcg., drops, units, etc.)	How often?



MEDICAL HISTORY

Your name _____

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IMMUNIZATIONS — Put an “X” in the appropriate box.

IMMUNIZATION	YEAR	DON'T KNOW	IMMUNIZATION	YEAR	DON'T KNOW
DPT (Diphtheria, Pertussis, Tetanus)			Measles Booster		
MMR (measles, mumps, rubella)			Hepatitis B		
HIB (haemophilus B conjugate)			Pneumovax		
Polio			Flu		
Varicella			Typhoid		
Tetanus Booster			Cholera		
Yellow Fever			Hepatitis A		

ADVANCE DIRECTIVES — Put an “X” in the appropriate box.

	YES	NO		YES	NO
I have a Living Will			I am including a copy		
I have a Health Care Proxy or Power-of-Attorney for Health Care			I am including a copy		
I am an Organ Donor			I am including a copy		



Your name _____

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TERMS OF MEMBERSHIP

- 1. Medical Information** — The member is responsible for keeping his/her medical information up-to-date and will notify *CallMD* when any information changes. If a member provides any information related to AIDS or HIV, including testing for the presence of the HIV + anti-body/antigen, results of such test, and/or a diagnosis(es) of AIDS and related conditions, the Member will be required to provide written authorization to release this information.
- 2. Transmission of Medical Information** — A member's Medical information will be mailed, faxed or released over the telephone when authorized, along with any documents the Member has supplied to *CallMD*. A member's Medical Information will be released only to qualified medical personnel for the purpose of the Member's care or for any other Member-authorized situation.
- 3. Service Interruption** — A Member's *CallMD* service may be interrupted if he/she does not remain a Member in good standing. A *CallMD* Member in good standing has: (a) verified his/her Medical information, (b) paid his/her Membership fee if applicable and not gone into arrears, and (c) has not provided *CallMD* with a written notice of cancellation. A Member's authorization to release medical information will be valid for the lifetime of his/her membership until he/she provides *CallMD* with a notice of cancellation or until a Member is no longer in good standing. A Member may not hold *CallMD* responsible for acting in reasonable reliance upon his/her authorization prior to the time that *CallMD* learns of the Member's cancellation or amendment.
- 4. General Release** — *CallMD* is obligated to use commercially reasonable efforts to ensure that the Member's Medical Information, as reviewed, verified, and corrected by the member, accurately reflects the information provided by the member. *CallMD* is not responsible for, and disclaims all liability for any and all damages arising due to any errors, inaccuracies or omissions in the Medical Information due to errors, inaccuracies or omissions in the information provided to *CallMD* by the Member.
- 5. Confidentiality** — *CallMD* will release any and all information only as authorized for disclosure by the Member and as permitted by law. *CallMD* will make every attempt to confirm that the requested information is received by the intended recipient. All *CallMD* memberships are maintained at the highest level of confidentiality and are never provided to other services.
- 6. Use of Information Provided by *CallMD*** — *CallMD* cannot guarantee that information provided to recipients will be used or acknowledged.



AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize *CallMD* and *CallMD* Physicians Association and/or its member physicians to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes, evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs managed care organization, Medicare/Medicaid or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions. I also give authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

PRINTED NAME

SIGNATURE Parent or guardian must sign for a member under 18 years of age.

Date: ____/____/____