**Name**_______________________________________________**Date**________________________________**Age**_____

**REASON FOR VISIT:**
_______________________________________________________________________________________________

**WHEN SYMPTOMS BEGAN:**
_______________________________________________________________________________________________

**PREVIOUS TREATMENTS:**
_______________________________________________________________________________________________

**CURRENT MEDICATIONS (over-the-counter/prescription/herbal):** **NONE** □
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**DRUG ALLERGIES: (**please select one**) YES** ☐ **NO** ☐
If **YES,** please list here ____________________________________________________________________________

**MEDICAL HISTORY** (**please check all that apply**):

| | | | | | |
|---|---|---|---|---|---|
| □Seasonal Allergies | □Diabetes | □ Headaches | □Moodiness-Excessive | □Eczema | □ HPV |
| □Asthma/Wheezing | □Diarrhea | □ Heart murmur | □Nausea/Vomiting | □ Prostate Disease | □ Venereal Disease |
| □Arthritis | □Crohn's/ Colitis | □ High blood pressure | □Nose bleeds | □ Hives | □ Herpes |
| □Cancer (type) ____________ | □Gall bladder trouble | □ Infections | □Osteoporosis | □ Stroke | □ Melanoma |
| □Chest pain | □Gout | □ Jaundice/ Hepatitis | □Pneumonia | □ Thyroid Disease | □ Basal Cell Carcinoma |
| □Convulsions/ Seizures | □Pregnant or Breastfeeding (currently) | □ Mental illness | □Psoriasis | □ Clotting Disorder | □ Squamous Cell Carcinoma |
| | | | | | □Contraceptive ________________ |

**FAMILY HISTORY (please check all that apply):**

□Asthma
□Bleeding Disorder
□Eczema
□Seasonal Allergies
□Breast Cancer
□Ovarian Cancer

□Prostate Cancer
□Colon Cancer
□Basal Cell/ Squamous Cell Carcinoma
□Melanoma
Where:__________________________

**SOCIAL HISTORY:**

Alcohol: (please select one)
□YES □ NO

Type:_________________
Amount: (per week)

Smoking: (please check one)
□YES □ NO

Packs Daily: ______________
How long?______________

**NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM**

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding :

- Unique Identifiers for health plans, providers, individuals, employers,
- Healthcare Transaction & Code Sets for transmitting date electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

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Spouse name____________________________________________________________________________
Parent name____________________________________________________________________________
Other name_____________________________________________________________________________
(Please give name and relationship such as boyfriend, sister, etc.)

I, ____________________________________________ have been informed of
Dr. Aria's notice of Privacy Practices.

____________________________________________
Patient signature Date