PLEASE PRINT CLEARLY AND ANSWER ALL QUESTIONS

Date:______________________ Home Phone: (____) _______________

E-mail:______________________ Cell Phone: (____) _________________

Mr. / Mrs.

Ms. /Miss. ______________________________________Birthday_________________Status_________

Address____City_____________State______Zip___________

Occupation___________________________________Employer_________________________________

Business Address________________________________ Business Phone (____) _________________

Spouse's Name_________________________________ Phone (____) ____________________________

Referred By:

Name____ Phone (____) ____________________________

Address______________________________________City_____________State_______Zip__________

Primary Care Doctor:

Name____ Phone (_____) ___________________________

OB/GYN:

Name____ Phone (_____) ___________________________

In Case of Emergency (someone not living with you):

Name____ Phone (_____) ___________________________

Address______________________________________City____________State_______Zip__________

Relationship____

Primary Insurance____________________________________ Phone (____) ____________________

Subscriber________________________________ ID# __________________Group/Policy#__________

Other Insurance____ Phone (_____) __________________

Subscriber____________________ ID# _______________ DOB_________ Group/Policy#_____________

DR. OSTROW DOES <u>NOT</u> ACCEPT NO-FAULT OR WORKERS COMPENSATION CASES. THIS HAS BEEN FULLY EXPLAINED TO ME. <u>I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL FEES THAT MAJOR MEDICAL INSURANCE DOES NOT COVER.</u> I ALSO AGREE TO DEPOSIT INSURANCE PAYMENTS AND PAY THE SAME AMOUNT TO DR. OSTROW WITHIN A WEEK BY PERSONAL CHECK OR CREDIT CARD.

SIGNATURE: ____**DATE:** __________________________

PATIENT QUESTIONNAIRE

PATIENT'S NAME | BIRTH DATE | SEX | S.M.W.D.

ADDRESS | TEL. NO.

INSURANCE | REFERRED BY | OCCUPATION

INSTRUCTIONS PUT ☑ IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

FAMILY HISTORY

	FATHER	MOTHER	BROTHER 1	BROTHER 2	BROTHER 3	BROTHER 4	SISTER 1	SISTER 2	SISTER 3	SISTER 4	SPOUSE	CHILDREN 1	CHILDREN 2	CHILDREN 3	CHILDREN 4	CHILDREN 5	CHILDREN 6
AGE (IF LIVING)																	
HEALTH (G) GOOD (B) BAD																	
CANCER																	
TUBERCULOSIS																	
DIABETES																	
HEART TROUBLE																	
HIGH BLOOD PRESSURE																	
STROKE																	
EPILEPSY																	
NERVOUSE BREAKDOWN																	
ASTHMA, HIVES, HAY FEVER																	
BLOOD DISEASE																	
AGE (AT DEATH)																	
CAUSE OF DEATH																	

PERSONAL HISTORY

HAVE YOU EVER HAD...	NO	YES	HAVE YOU EVER HAD...	NO	YES	HAVE YOU EVER HAD...	NO	YES
MIGRAINE HEADACHES			☐ RHEUMATIC FEVER ☐ HEART DISEASE			ANY ☐ BROKEN ☐ CRACKED BONES		
FREQUENT ☐ COLDS ☐ STREP THROAT			☐ HIGH ☐ LOW BLOOD PRESSURE			RECURRENT DISLOCATIONS		
CHRONIC FATIQUE			DIABETES			☐ CONCUSSION ☐ HEAD INJURY		
☐ HAY FEVER ☐ ASTHMA			☐ ULCER ☐ GASTRITIS			EVER BEEN KNOCKED UNCONSCIOUS?		
☐ HIVES ☐ ECZEMA			APPENDICITIS			☐ FOOD ☐ CHEMICAL ☐ DRUG POISONING		
☐ PSORIASIS ☐ SHINGLES			GALL BLADDER DISEASE			EXPLAIN:		
☐ POLIO ☐ MENINGITIS			☐ IRRITABLE BOWEL ☐ COLITIS					
☐ PNEUMONIA ☐ PLEURISY			☐ PARASITES ☐ WORMS			ANY OTHER DISEASE?		
TUBERCULOSIS			CANCER			EXPLAIN:		
EPILEPSY			NERVOUS BREAKDOWN					
☐ KIDNEY DISEASE ☐ STONES			☐ ARTHRITIS ☐ RHEUMATISM			AGE HOW OLD DO YOU FEEL?		
☐ GONORRHEA ☐ SYPHILIS			☐ NEURITIS ☐ NEURALGIA			HEIGHT HAVE YOU LOST HEIGHT?		
☐ JAUNDICE ☐ HEPATITIS			☐ BURSITIS ☐ LUMBAGO ☐ SCIATICA			WEIGHT IDEAL BODY WEIGHT?		
ANEMIA			WHIPLASH WHEN?					

ALLERGIES

ARE YOU ALLERGIC TO...	NO	YES	ARE YOU ALLERGIC TO...	NO	YES	ARE YOU ALLERGIC TO...	NO	YES
☐ PENICILLIN ☐ SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
☐ ASPIRIN ☐ CODEINE ☐ MORPHINE			EXPLAIN			EXPLAIN		
☐ MYCINS ☐ OTHER ANTIBIOTICS								
☐ TETANUS ☐ ANTITOXIN ☐ SERUMS			ADHESIVE TAPE			☐ NAIL POLISH ☐ OTHER COSMETICS		

SURGERY

HAVE YOU HAD REMOVED...	NO	YES	HAVE YOU HAD REMOVED...	NO	YES	HAVE YOU HAD REMOVED...	NO	YES
TONSILS			☐ OVARY ☐ OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			HAD ANY OTHER OPERATIONS		
GALL BLADDER			EVER HAVE A TRANSFUSION			BEEN HOSPITALIZED FOR ANY ILLNESS		
UTERUS			☐ BLOOD ☐ PLASMA			EXPLAIN		

X-RAYS

X-RAYS	NO	YES	DATE	AB NORMAL RESULTS	X-RAYS	NO	YES	DATE	AB NORMAL RESULTS
EVER HAVE X-RAYS OF...					COLONOSCOPY				
CHEST					ENDOSCOPY				
☐ STOMACH ☐ COLON					STRESS TEST				
GALL BLADDER					PROSTATE / RECTAL				
BACK					GYN EXAM				
EXTREMETIES					☐ MRI ☐ CT SCAN				
MAMMOGRAM									

SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD...	NO	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD...	NO	YES
ANY ☐ EYE DISEASE ☐ EYE INJURY ☐ IMPAIRED SIGHT			COUGH ☐ FREQUENT ☐ CHRONIC		
ANY ☐ EAR DISEASE ☐ EAR INJURY ☐ IMPAIRED HEARING			☐ CHEST PAIN ☐ ANGINA		
ANY TROUBLE WITH ☐ NOSE ☐ SINUSES ☐ MOUTH ☐ THROAT			☐ PALPITATIONS ☐ FLUTTERING HEART		
SEASONAL ALLERGY			SWELLING OF: ☐ HANDS ☐ FEET ☐ ANKLES		
HEADACHES: ☐ FREQUENT ☐ SEVERE			SHORTNESS OF BREATH: ☐ EXERTION ☐ NIGHT		
FAINTNESS OR DIZZINESS			NIGHT SWEATS		
CLENCHING OR GRINDING TEETH			☐ FREQUENT URINATION ☐ EXCESSIVE THIRST		
BLEEDING GUMS			DROWSY AFTER MEALS?		
FREQUENT TIREDNESS OR FATIQUE			GET SHAKY INSIDE IF HUNGRY?		
TROUBLE REMEMBERING THINGS			CRAVE: ☐ CANDY ☐ CHOCOLATE ☐ OTHER		
DECREASED SEXUAL INTEREST OR PLEASURE			HAVE TO URINATE AT NIGHT?		
THYROID: ☐ OVERACTIVE ☐ UNDERACTIVE ☐ ENLARGED			PROSTATE TROUBLE		
COLDS HANDS OR FEET			☐ NARROWED URINARY STREAM ☐ HESITATION		
SKIN DISEASE			☐ BLADDER PROBLEMS ☐ INCONTINENCE		
INDIGESTION OR HEARTBURN			STIFF JOINTS IN THE MORNING		
EXCESSIVE BLOATING OR BELCHING			LEG PAIN WHEN WALKING		
☐ CONSTIPATION ☐ DIARRHEA			MUSCLE TWITCHING OR CRAMPS		
☐ HEMORRHOIDS ☐ RECTAL BLEEDING			NUMBNESS OR TINGLING		
☐ ANY CHANGE IN APPETITE? ☐ EATING HABITS?			DIFFICULTY FULLY TURNING HEAD		
RECENT WEIGHT GAIN OR LOSS?			DIFFICULTY SITTING, BENDING, OR LIFTING		
VEGETARIAN? ☐ OVO ☐ LACTO ☐ FISH			UNCOORDINATION (DROP OR BUMP INTO THINGS)		

IMMUNIZATION - EKG

HAVE YOU HAD...	NO	YES	HAVE YOU HAD...	NO	YES
SMALLPOX VACCINATION (WITHIN LAST 7 YEARS)			POLIO SHOTS (WITHIN LAST 2 YEARS)		
TETANUS SHOT (NOT ANTITOXIN)			AN ELECTROCARDIOGRAM WHEN		

HABITS

DO YOU...	NO	YES	DO YOU USE...	NEVER	OCC.	FREQ.	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			BIRTH CONTROL PILLS				
SLEEP WELL			TRANQUILIZERS				
AVERAGE 8 HOURS SLEEP (PER NIGHT)			SLEEPING PILLS, ETC.				
DO YOU REMEMBER YOUR DREAMS?			ASPIRINS, ETC.				
HAVE REGULAR BOWEL MOVEMENTS?			CORTISONE				
SEX - ENTIRELY SATISFACTORY			ALCOHOLIC BEVERAGES				
LIKE YOUR WORK (HOURS PER DAY) ☐ INDOORS ☐ OUTDOORS			COFFEE (CUPS PER DAY)				
WATCH TELEVISION (HOUSE PER DAY)			TOBACCO: ☐ CIGARETTES (PKS PER DAY)				
READ (HOURS PER DAY)			☐ CIGARS ☐ PIPE ☐ CHEWING TOBACCO				
HAVE A VACATION (WEEKS PER YEAR)			☐ SNUFF				
HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM			APPETITE DEPRESSANTS				
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			THYROID MEDICATION: ☐ NO ☐ YES, IN PAST ☐ NONE NOW NOW ON GR. DAILY				
RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK.			HAVE YOU EVER TAKEN... ☐ INSULIN ☐ TABLETS FOR DIABETES ☐ HORMONE SHOTS ☐ TABLETS ☐ NO				

WOMEN ONLY

MENSTRUAL HISTORY...				NO	YES
AGE AT ONSET			ARE YOU REGULAR: ☐ HEAVY ☐ MEDIUM ☐ LIGHT		
USUAL DURATION OF PERIOD DAYS			DO YOU HAVE ☐ TENSION ☐ DEPRESSION BEFORE PERIOD		
CYCLE (START TO START) DAYS			DO YOU HAVE ☐ CRAMPS ☐ PAIN WITH PERIOD		
DATE OF LAST PERIOD			DO YOU HAVE HOT FLASHES		
PREGNANCIES	NO	YES		NO	YES
CHILDREN BORN ALIVE (HOW MANY)			STILL BORN (HOW MANY)		
CESAREAN SECTIONS (HOW MANY)			MISCARRIAGES (HOW MANY)		
PREMATURES (HOW MANY)			ANY COMPLICATIONS		

EMOTIONS

ARE YOU OFTEN...	NO	YES	ARE YOU OFTEN...	NO	YES
DEPRESSED			JUMPY		
ANXIOUS			JITTERY		
IRRITABLE			IS CONCENTRATION DIFFICULT?		

Ostrow & Associates

Osteopathic Musculoskeletal Medicine
Osteopathic Diagnosis and Treatment
115 East 57th Street 16th FL
New York, NY 10022

RE: X-Ray Duplication Policy

In the course of treatment in our office, it may be necessary for you to have X-rays taken. In accordance with New York State legal precedence, the original films become part of the permanent medical records and are the property of this office. The information that the X-rays provide in the form of a report, or duplicates, can be made available to you. New York State Public Health Policy Regulations allow physicians to maintain the original X-ray copies except in cases of emergencies. Duplication fees will be based on the number and size of films that are copied.

Signature ______________________________

Gary L. Ostrow, D.O., P.C.
115 East 57th Street 16th FL
New York, New York 10022
Telephone: (212)-838-8265

THIS NOTIFICATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. Government regulators established a privacy rule (''HIPPA'') governing protected health information. This notice tells you about how it may be used, and about certain rights you have.

Minerva Cabralda, Privacy Officer, is in charge of privacy matters at our office. You can contact her at 212-838-8265 if you desire further information, or have any questions or concerns

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use medical information for health care operations without further specific notice to you, or written authorization by you. Such as, our accountants may see your name, dates of treatment and procedure codes during audits of our books. Also, we may use your information for financial services, quality assurance, risk reduction, and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required by public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
5. Required by law in judicial or administrative proceedings;
6. Required by law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by to avert a serious threat of health and safety;
11. Permitted by law and required by military authorities if you are a member of armed forces of the United States;

New York State law provided additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above\. Except as stated below, we are not required to agree to such restrictions.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for research or public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

If you receive this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to:

Minerva Cabralda
Privacy Officer
115 E 57st, 16Fl
New York, NY 10022
Tel. (212) 8388265

No retaliatory action will be taken against you for any complaint you may make.

I have received a paper copy of this notice.

____
Signature

____
Print Name

____
Date

I make the following special requests for confidential communications:

____

____

____

____________________ ____________________
Signature Date

Gary L. Ostrow, D.O., P.C.

115 East 57th Street 16th FL
New York, New York 10022
Telephone: (212)-838-8265

Request for Restrictions/ Changes in the way we communicate with patient

Re: Confirmation of appointments

Patient name______________________________

Address__________________________________

____

____

Date of Birth______________________________

In what way do we communicate with you regarding confirmation of appointments?

Can we call you at your residence?	Yes	No
Can we call you at work?	Yes	No
Can we leave messages with your family members on your answering machine?	Yes	No
Can we leave messages on your machine at work?	Yes	No

Do you have any specific instructions regarding the way we communicate with you?

____

Signature of patient/guardian: ________________________________ Date:____________________