Patient Information:

Last Name:_____ First Name:_____ MI: __

Street Address:_____

City:_____ State: _____ Zip:_____

Home Phone:_____ Work Phone:_____ Ext_____

Emergency Contact: _____

Date of Birth: ___/___/____ Social Security: _____

Sex: _____ Marital Status: _____ Email:_____

Current Primary Care Provider: _____

Employer Information:

Name of Company: _____

Street Address:_____

City:_____ State: _____ Zip:_____

Phone number:_____

Contact Name:_____

I hereby affirm that the preceding information is true to the best of my knowledge

Patient Signature:_____

150 KENNEDY DRIVE
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802–448–1414(F)

CHAMPLAIN MEDICAL ASSOCIATES

PRE EMPLOYMENT/POST OFFER EMPLOYEE HISTORY

NAME (last, first, mi)

_____Date_____

CURRENT MEDICAL
PROVIDER_____

PRIOR TYPES OF WORK YOU HAVE DONE:
_____

PAST EXPOSURES TO: ____dust ___fumes ____chemicals ____ radiation
___loud noises? (Circle any that apply and describe)

PAST MEDICAL CONDITIONS: (circle any that apply and describe)
_____car accident ___loss of consciousness _____heart attack ____loss of vision _____abnormal heart rhythm _____seizure ____head injury ____stroke ____back injury _____psychiatric disorder ____broken bones ____strains/sprains

OTHER PAST MEDICAL CONDITIONS/SURGERIES/HOSPITALIZATIONS:

CURRENT MEDICAL CONDITIONS: please list

CURRENT MEDICATIONS (prescriptions, inhalers, over the counter, alternatives)

FAMILY MEDICAL HISTORY (Please include heart disease, diabetes, cancer, hypertension, etc.)

Mother	Sisters
Father	Brothers
Grandparents	Children

ALLERGIES (to medications, environment, foods)

SOCIAL HISTORY
Do you use tobacco _____no ____yes How many cigarettes/Day? ____ For ____years?
_____used to smoke but quit

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How many alcoholic drinks do you consume per day? _____ Per week? _____

Do you use recreational drugs?

REVIEW OF SYSTEMS:

Do you have any of the following?	Yes	No	Do you have any of the following?	Yes	No
Weight gain/weight loss (circle)	Y	N	Palpitations/skipped beats	Y	N
Fevers	Y	N	Chest pain or tightness	Y	N
Headaches	Y	N	Indigestion or Heartburn	Y	N
Vision problems/corrective lenses	Y	N	Abdominal pain	Y	N
Dizziness/Vertigo	Y	N	Diarrhea/constipation	Y	N
Difficulty hearing	Y	N	Irregular periods	Y	N
Numbness/tingling in extremities	Y	N	Frequent urinary tract infections	Y	N
Sinus problems	Y	N	Kidney stones	Y	N
Tiredness/falling asleep by day	Y	N	Back pain	Y	N
Unable to tolerate heat or cold	Y	N	Joint pain or swelling	Y	N
Shortness of breath	Y	N	hernia	Y	N
Wheezing	Y	N	Swelling of legs	Y	N
Cough	Y	N	Skin problems (rash, eczema)	Y	N
Pauses in breathing while asleep?	Y	N	Diabetes or elevated blood sugar	Y	N

Explain yes answers here:

If you work in health care, nursing home or childcare have you had the following:

Chickenpox disease (or varicella vaccine)?	Date
Hepatitis vaccine series?	Date
PPD test (for TB)?	Date
TDaP (Tetanus, Diphtheria, Pertussis) vaccine?	Date
Seasonal flu shot?	Date

DO YOU HAVE ANY CONDITION (PHYSICAL, MEDICAL PSYCHOLOGICAL) THAT WOULD REQUIRE SPECIAL ACCOMODATIONS IN ODER FOR YOU TO PERFORM YOUR JOB? _____
YES _____NO (If yes please specify) _____

_____

Signature of Employee_____ Date_____

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DATE: ____/____/20

I AUTHORIZE CHAMPLAIN MEDICAL ASSOCIATES TO RELEASE OF A COPY OF THE FOLLOWING MEDICAL RECORDS TO:

TO: _____ _____

ADDRESS: _____

CITY _____

STATE: _____

ZIP: _____

__ PHYSICALS (INCLUDING DOTS)
__ PROGRESS NOTES
__ LAB/RADIOLOGY/ OTHER DIAGNOSTIC AND CARDIOLOGY RESULTS
__ CONSULTATIVE OR/DISCHARGE REPORTS
__ MED LISTS
__ ALL OF THE ABOVE

_____ _____ _____

Name of patient Signature

Date of Birth: _____

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ Date: _____

Printed Name

_____

Signature

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