6150 SW 76 St, 1st Floor
Miami, FL 33143
Tel: (786) 709-9990
Fax : (800) 445-9844

Medical History Update Form

Patient Name: ____ **DOB:** ______/______/______

In the past 6 months, have you been seen by any specialists?

If Yes, please explain

NO ☐ **YES** ☐ ____

____

In the past 6 months, have you been treated by any providers other than your primary care physician?

If Yes, please explain

NO ☐ **YES** ☐ ____

____

In the past 6 months, have you been hospitalized?

If Yes, please explain

NO ☐ **YES** ☐ ____

____

In the past 6 months, have you had any surgeries?

If Yes, please explain

NO ☐ **YES** ☐ ____

____

________________________________ ______/______/______

Patient / Patient Representative Name **Date**

____

Patient / Patient Representative Signature

Prime MD
MIAMI

6150 SW 76 St, 1st Floor
Miami, FL 33143
Tel: (786) 709-9990
Fax : (800) 445-9844

Patient Name:____DOB_________________

Depression Screening

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______
=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

6150 SW 76 St, 1st Floor
Miami, FL 33143
Tel: (786) 709-9990
Fax : (800) 445-9844

MEDICAL RECORD RELEASE FORM

Prime MD Miami

Rekha Kini, MD
Kim Bango, MD

Patient Name ______________________________________ Date of Birth ________________________

I hereby authorize the below listed entity to release medical information to **Prime MD Miami**:

Name: ____ Telephone#: ____________

Address: ____ Fax#: _______________

____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records: ______________________________________
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.} ______________________

____ ____________________

Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.