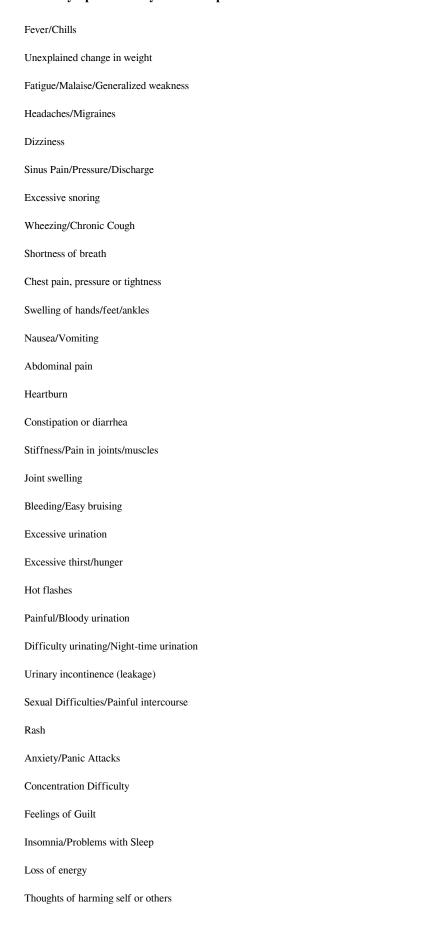
## **Medical History**

Full Name		
	First Name	Last Name
What is your Gend	er?	
Male		
Female		
		any members of your immediate rela
Asthma		
Cancer Cardiac disease		
Diabetes		
Hypertension		
Psychiatric disorder		
Epilepsy		

## Check the symptoms that you have experienced in the PAST 6 WEEKS



For women only: Date of la	stomenstruaDp,	eriod Year	
For women only: Number of pregnancies			
Number of live births			
Are you taking any hormones or birth control?	Yes	No	
Do you have irregular or painful periods?	Yes	No	
Are you currently taking an	ny medication?		
Yes			
No			
If so, please list:			
-			
Do you have any medication	n allergies?		
Yes			
No			
Not Sure			

Do you use or do you have history of using tobacco?

•								•			
I)n	UOII	1156	$\mathbf{or}$	dΩ	VOII	have	history	Λť	using	illegal	drugs?
~	you	use	O.	uv	Jou	mu , c	III SCOL y	O.	ubilia	megai	ur ugo.

How often do you consume alcoho	now orten a	o you	Consume	aiconoi
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Daily	Weekly	Monthly
Occasionally	Never	

## JCertain Waivers under HIPAA.

- (a) Patient acknowledges that PharmAssist, PLLC guarantees that communications with Physician using electronic mail ("e-mail"), facsimile, video chat, instant messaging, and cellular telephone are secure or confidential methods of communications. Accordingly, Patient expressly waives PharmAssist's obligations under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, and all rules and regulations promulgated thereunder (collectively, "HIPAA"), and other state and federal laws and regulations applicable to the use, maintenance, and disclosure of patient-related information, to guarantee confidentiality with respect to correspondence using such means of communication. Patient acknowledges that all such communications may become a part of Patient's medical records maintained by PharmAssist, PLLC.
- (b) By providing Patient's e-mail address to PharmAssist, PLLC -Patient authorizes PharmAssist to communicate with Patient by e-mail regarding Patient's "protected health information" ("PHI") (as defined under HIPAA) and Patient understands and agrees to the following:
  - E-mail is not necessarily a secure medium for sending or receiving PHI and, accordingly, any third party may gain access to such PHI;
  - Although PharmAssist, PLLC will make all reasonable efforts to keep e-mail communications confidential and secure, PharmAssist, PLLC cannot assure or guarantee the absolute confidentiality of such e-mail communications.

Patient Initials:			

Patient acknowledges and agrees that PharmAssist, PLLC, along with their assigns, will be entitled to use any data, discoveries, results, improvements or other information resulting from the Services for any lawful purpose whatsoever, including, but not limited to, internal research, academic or other publications or commercial purposes. All data will be kept on a Cloud Based system that is password protected, and accessible to PharmAssist, PLLC staff.

Patient Name				Today's l	<b>Date</b>	
				Month	Day	Year
Patient Date of Birth						
	Month	Day	Year			
I,						
	First Name	L	ast Name		-	
obtain and access to medical information					secure	
				Month	Day	Year
Patient Date of Birth	Month	Day	Year			
Any exceptions to medical record access:						