STANDARD Medical History Disclosure (MHD)—Teladoc

To be completed for all members 7 years of age and older. A pediatric MHD should be completed for members under 7 years of age.

To be completed by the Patient or Guardian:***LEGAL NAME:** ________________________ ***GENDER:** M / F

***COMPANY NAME:** ________________________

***BIRTHDATE:** ________________ **EMPLOYEE/MEMBER ID #** (if applicable)**:** ____________

***MAILING STREET ADDRESS:** ________________ You are the ❑ **Primary** ❑ **Dependent** Member

***CITY/STATE/ZIP:** ________________________ **Ethnicity:** ____________

Phone Number: ________________ **Alternate Number:** ________________

PATIENT CURRENT *Height: __________ ***Weight:** __________ **Date of Last Physical:** __________

Date of last Tetanus Shot:__________ **Date of last visit to Primary Care Physician:** __________

Primary Care Physician:__________ **Primary Care Physician's contact number:** __________

Complete the following questions relative your medical history. The MHD is confidential and only reviewed by a physician.
All questions marked with an asterisk (*) must be answered prior to requesting a consult.

Smoke / use tobacco	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No	Use recreational drugs	❑ Yes ❑ No
Drink alcohol	❑ Yes ❑ No	Exercise	❑ Yes ❑ No	Work around hazardous/ toxic chemicals	❑ Yes ❑ No
Been disabled	❑ Yes ❑ No	Take medication	❑ Yes ❑ No	Traveled overseas in the last 2 months	❑ Yes ❑ No
Get 8 hrs sleep daily	❑ Yes ❑ No	Have a chronic condition	❑ Yes ❑ No	Yearly flu shots	❑ Yes ❑ No

If you are under the care of a Specialist please list name and number of Specialist including reason/condition for which you are being treated by the Specialist:________________________

***Medical History**: Do you currently, or have you ever had any problems in the following areas?
Mark "Yes" or "No". If condition is current, notate by checking the "Current" box.

		Current			Current			Current
Asthma	❑ Yes ❑ No	❑	Leg/Feet Problems	❑ Yes ❑ No	❑	Depression	❑ Yes ❑ No	❑
Pneumonia	❑ Yes ❑ No	❑	Nose Bleeds	❑ Yes ❑ No	❑	Ear Problems	❑ Yes ❑ No	❑
Chronic Cough	❑ Yes ❑ No	❑	Headaches/Migraines	❑ Yes ❑ No	❑	Hearing Problems	❑ Yes ❑ No	❑
Frequent 'Colds'	❑ Yes ❑ No	❑	Throat Problems	❑ Yes ❑ No	❑	Contacts/Glasses	❑ Yes ❑ No	❑
H1N1/ Swine Flu	❑ Yes ❑ No	❑	Mouth Sores	❑ Yes ❑ No	❑	Seizure Problems	❑ Yes ❑ No	❑
Seasonal Allergies	❑ Yes ❑ No	❑	High Blood Sugar	❑ Yes ❑ No	❑	Stroke	❑ Yes ❑ No	❑
Lung Problems	❑ Yes ❑ No	❑	Chronic Diarrhea	❑ Yes ❑ No	❑	ADD/ADHD	❑ Yes ❑ No	❑
Liver or Pancreas Problems	❑ Yes ❑ No	❑	Chronic Constipation	❑ Yes ❑ No	❑	Metabolic Disease	❑ Yes ❑ No	❑
Kidney Problems	❑ Yes ❑ No	❑	Urinary Tract Infections	❑ Yes ❑ No	❑	Tonsil/Adenoid Problems	❑ Yes ❑ No	❑
Elevated Cholesterol or Triglycerides	❑ Yes ❑ No	❑	Breast Problems	❑ Yes ❑ No	❑	Thyroid Disorder	❑ Yes ❑ No	❑
Stomach Pain	❑ Yes ❑ No	❑	Digestive/Stomach Problems	❑ Yes ❑ No	❑	Ovaries or Uterus Problems	❑ Yes ❑ No	❑
Stomach Ulcers	❑ Yes ❑ No	❑	Hepatitis	❑ Yes ❑ No	❑	Heart Surgery	❑ Yes ❑ No	❑
Anemia	❑ Yes ❑ No	❑	HIV/ AIDS	❑ Yes ❑ No	❑	Laser Eye Surgery	❑ Yes ❑ No	❑
High Blood Pressure	❑ Yes ❑ No	❑	Sleep Apnea	❑ Yes ❑ No	❑	Undergone Surgery	❑ Yes ❑ No	❑
Diabetes	❑ Yes ❑ No	❑	Cancer	❑ Yes ❑ No	❑	Joint or Muscle Problems	❑ Yes ❑ No	❑
Heart Problems	❑ Yes ❑ No	❑	Blood Disorder	❑ Yes ❑ No	❑	Back/Chronic Pain	❑ Yes ❑ No	❑
Swollen Painful Joints	❑ Yes ❑ No	❑	Heart Disease	❑ Yes ❑ No	❑	Gout	❑ Yes ❑ No	❑
Chronic Muscle Aches	❑ Yes ❑ No	❑	Skin Problems	❑ Yes ❑ No	❑	Testicles or Prostate Problems	❑ Yes ❑ No	❑
Hand/Arm Problems	❑ Yes ❑ No	❑	Psychological Disorders	❑ Yes ❑ No	❑	Hospitalization	❑ Yes ❑ No	❑
Other (explain):								

***Allergies** (note reaction for each)

***Medication**	**Reaction**
***Food**	

***Please List All Current Medications.** Include quantity and frequency (whether prescribed or over-the-counter):________________________

Tests

Test	Yes/No	Date of most recent	Test	Yes/No	Date of most recent
Chest X-ray	❑ Yes ❑ No		CBC	❑ Yes ❑ No	
Stress Test	❑ Yes ❑ No		HIV Test	❑ Yes ❑ No	
Fasting Blood Sugar	❑ Yes ❑ No		Thyroid Panel	❑ Yes ❑ No	
Lipids (Cholesterol)	❑ Yes ❑ No		Hearing Test	❑ Yes ❑ No	
Chemistry Panel	❑ Yes ❑ No		Vision Test	❑ Yes ❑ No	
EKG	❑ Yes ❑ No		Colonoscopy	❑ Yes ❑ No	
Urine Test	❑ Yes ❑ No		TB (PPD) Test	❑ Yes ❑ No	
Other (details):					

Family History

Question	Answer	Relationship to Patient
1. Asthma	❑ Yes ❑ No	
2. Metabolic Disease	❑ Yes ❑ No	
3. Stroke	❑ Yes ❑ No	
4. Cystic Fibrosis	❑ Yes ❑ No	
5. Cancer (and type)	❑ Yes ❑ No	
6. Diabetes (type I or II)	❑ Yes ❑ No	
7. Elevated Cholesterol	❑ Yes ❑ No	
8. Heart Disease	❑ Yes ❑ No	
9. Early/Unexplained Death	❑ Yes ❑ No	
10. High Blood Pressure	❑ Yes ❑ No	
11. Seasonal Allergies	❑ Yes ❑ No	
12. Sickle Cell Anemia	❑ Yes ❑ No	
13. Thyroid Disease	❑ Yes ❑ No	
14. Other (explain)	❑ Yes ❑ No	

Terms & Conditions: Read the following terms and conditions of your Teladoc membership and indicate that you understand and agree to the terms by signing below.

1. You are entering into a doctor/patient relationship with the doctors of TelaDoc Physicians, P.A., and you agree to pay for medical consultations at the time a medical consultation is requested, unless payment arrangements have been established through your employer, association, or other entity.
2. You agree to the entry of your medical records into the Teladoc computer database and understand that all reasonable measures have been taken to safeguard your medical information, in accordance with federal HIPAA standards, but no computer or phone system is totally secure. Teladoc recognizes your privacy and, in accordance with our Privacy Policy, will not release information to anyone without your written authorization or as required by law, or in accordance with your health insurer's privacy policy if applicable.
3. You agree to complete a medical history disclosure form that Teladoc will store electronically and make available to each Teladoc physician who performs a telephonic consultation for you.
4. You acknowledge that you already have a primary care physician and that Teladoc is not a substitute for your primary care physician.
5. You agree to designate TelaDoc Physicians, P.A. as your physician when your primary care physician is not available.
6. You acknowledge that Teladoc physicians will not prescribe any Drug Enforcement Agency controlled substances nor do they guarantee that a prescription will be written.
7. Additionally, there is no guarantee that you will be accepted as a patient.
8. If you are accepted as a patient by a Teladoc physician, you have a right to your medical records in accordance with applicable law.

I HAVE READ, UNDERSTAND AND HEREBY CONSENT AND AGREE TO ALL OF THE TERMS AND CONDITIONS DESCRIBED HEREIN.

If the patient is a minor: I am the parent or legal guardian for the above referenced child and am authorized to consent to medical treatment for such child. I am authorized and have true and complete knowledge of this child's medical history to accurately and fully complete the medical disclosure form for the child referenced above in the event that the services of a doctor of the TelaDoc Physicians, P.A. are sought for such child.

REQUIRED → **Signature of Patient or Guardian:** ______________________ **Relationship to Patient:** __________

Print Patient Name: ______________________ **Date of Completion:** __________

Person Completing Form: ______________________ **Relationship to Patient:** __________

Please fax or mail this completed form to the Teladoc Customer Relations Department:

Fax (972) 661-2312 * 4100 Spring Valley, Ste 515, Dallas TX 75244