

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use recreational drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drink alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work around hazardous/ toxic chemicals	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	Take medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Traveled overseas in the last 2 months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Get 8 hrs sleep daily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have a chronic condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yearly flu shots	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Leg/Feet Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Frequent 'Colds'	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Throat Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Contacts/Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
H1N1/ Swine Flu	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Mouth Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Seizure Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	High Blood Sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Liver or Pancreas Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Metabolic Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Tonsil/Adenoid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Elevated Cholesterol or Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Breast Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Digestive/Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Ovaries or Uterus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	HIV/ AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Laser Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Undergone Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Joint or Muscle Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Back/Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Swollen Painful Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Chronic Muscle Aches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Testicles or Prostate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Hand/Arm Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
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): _____

STANDARD: Teladoc Medical History Disclosure

Tests		Date of most recent		Date of most recent
Chest X-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No		CBC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stress Test	<input type="checkbox"/> Yes <input type="checkbox"/> No		HIV Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fasting Blood Sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No		Thyroid Panel	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lipids (Cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hearing Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemistry Panel	<input type="checkbox"/> Yes <input type="checkbox"/> No		Vision Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No		Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urine Test	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB (PPD) Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (details):				

Family History

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

- You are entering into a doctor/patient relationship with the doctors of Teladoc Physician Association, 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.
- 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.
- 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.
- You acknowledge that you already have a primary care physician and that Teladoc is not a substitute for your primary care physician.
- You agree to designate Teladoc Physician Association as your physician when your primary care physician is not available.
- You acknowledge that Teladoc physicians will not prescribe any Drug Enforcement Agency controlled substances nor do they guarantee that a prescription will be written.
- Additionally, there is no guarantee that you will be accepted as a patient.
- 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 Physician Association 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 mail this completed form to the Teladoc Customer Relations Department:

4100 Spring Valley, Ste 600, Dallas TX 75244