



18303 Ten Mile Road
Suite 500
Roseville, MI 48066

Dear Patient,

Welcome to St. John Center for Wellness and Family Medicine. We are happy to assist you in promoting both you and your family's well being. We are extremely pleased with how so many of our families have been sharing the good news about our practice growth and our emphasis on personalized patient care. Our Providers and support staff are dedicated to making sure your experience in our office is one that you will feel good about for years to come.

To help us ensure that your first visit goes smoothly, please take a few minutes to fill out these registration and history forms completely, if possible, include a copy of your insurance card. After completing the forms please return them to our office in the enclosed envelope, **at least 1 week prior to your scheduled appointment date. If the paperwork is not received your appointment will be canceled.** It is of the utmost importance that you arrive 15 minutes prior to your appointment time to complete the registration process; any tardiness on your part will delay your appointment.

Lastly, please remember to bring the following with you to your appointment:

- ❖ Health history records
- ❖ Immunization records
- ❖ List of current medications, vitamins and supplements
- ❖ Insurance cards
- ❖ Insurance co-pay (if there is a co-payment required by your insurance company contract each time you visit the office for any service. Payment is always expected at the time of service.)

If you have any questions concerning the forms or need to cancel or reschedule your appointment, please call (586) 498-5160.

Yours in Good Health,

St John Center for Wellness and Family Medicine Staff

4/08



To come from I-94:

Get off at Ten Mile Rd. exit and head West towards Gratiot. We will be on the North (right) side on Ten Mile in the Pointe East Office Complex. Once in the complex we will be located at 18303 Suite 500, which is the last building on the left hand side.

Phone # 586-498-5160

To come from Gratiot:

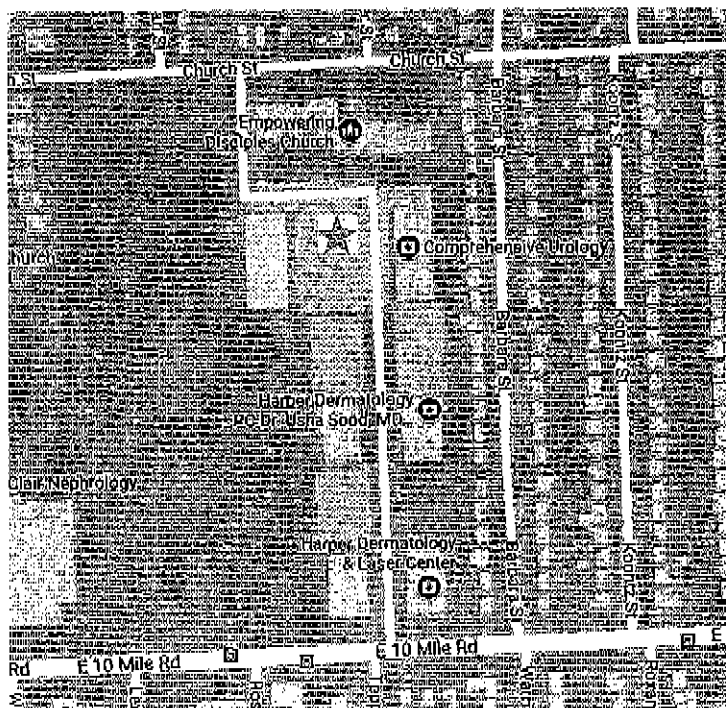
Take Ten Mile Rd. east toward Kelly. We will be on the North (left) side on Ten Mile Rd. in the Pointe East Office Complex. Once in complex we will be located at 18303 Suite 500, which will be the last building on the left hand side.

Phone #586-498-5160

From Gratiot / I-94



Point East Office Complex





St. John Health Notice of Privacy Practices

1. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

2. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Health facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at www.stjohn.org.

3. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

We may use and disclose your PHI for the following reasons:

- 3.1.1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.
- 3.1.2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.
- 3.1.3. **For health care operations.** We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and others in order to make sure we are complying with the laws that affect us.

3.2. Certain Other Uses and Disclosures That Do Not Require Your Consent

- 3.2.1. **When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.
- 3.2.2. **For public health activities.** For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
- 3.2.3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- 3.2.4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
- 3.2.5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct research.
- 3.2.6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- 3.2.7. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- 3.2.8. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.
- 3.2.9. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.
- 3.2.10. **Fundraising activities.** We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

3.3. Uses and Disclosures to Which You Have an Opportunity to Object

- 3.3.1. **Patient directories.** We may include your name, location in this facility, general condition and religious affiliation (if any) in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part.
- 3.3.2. **Disclosure to family, friends, or others.** We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.
 - 3.3.2.1. Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

3.4. All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI.

If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- 4.1. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
- 4.2. The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.
- 4.3. The Right to See and Get Copies of Your PHI.** In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, we will charge you a reasonable copying fee.
- 4.4. The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures listed in section 3.1, 3.2 and 3.3. The list also will not include any uses or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you \$25 for each additional request.
- 4.5. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.
- 4.6. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **St. John Health HIPAA Privacy Office** - (See section 7 of this Notice.)

You also may send a written complaint to:

Secretary of the Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

We will take no retaliatory action against you if you file a complaint about our privacy practices.

6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments and units of the following entities:

Brighton Hospital	Father Murray Nursing Center	St. John Health Foundation
Providence Hospital and Medical Centers	St. John Senior Community	St. John Health Occupational Health Partners
St. John Detroit Riverview Hospital	St. John Home Care	Affiliated Health Services, Inc.
St. John Hospital and Medical Center	St. John Hospice	Community Health Investment Corp.
St. John Macomb Hospital	St. John Home Infusion	St. John Health
St. John NorthEast Community Hospital	St. John Home Medical Equipment	East Lake Cardiovascular
St. John North Shores Hospital	Medical Resources Group	Harper Metro Radiology
St. John Oakland Hospital	Michigan Mobile Lithotripsy	Woods Cardiovascular Associates
St. John River District Hospital	Eastwood Clinics	

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for purposes of treatment, payment, or hospital operations as described in this notice.

7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the Medical Resources Group HIPAA Privacy Officer at 586-226-6801. All complaints must be submitted in writing to:

Medical Resources Group
HIPAA Privacy Officer
43800 Garfield, Suite # 201
Clinton Twp., MI 48038

8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003.

THE ST. JOHN CENTER FOR WELLNESS AND FAMILY MEDICINE

18303 Ten Mile Road Suite 500 Roseville, MI 48066 Phone: 586.498.5160 Fax: 586.498.5199

PATIENT REGISTRATION FORM

P A T I E N T	Name Last First Middle				
	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				
	Address				
	City		State	Zip Code	
	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Social Security Number	
	Phone HOME:	CELL:	WORK:		
	Occupation	Employer	E-MAIL		
Pharmacy Location/Pharmacy Phone Number					
R E S P O N S I B L E P A R T Y	Name Last First Middle				
	Address				
	City		State	Zip Code	
	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Social Security Number	
	Phone HOME:	CELL:	WORK:		
	Occupation	Employer	E-MAIL		
	Primary Policy Holder is: <input type="checkbox"/> Patient <input type="checkbox"/> Responsible Party				
	Primary Insurance		Plan Number	Group Number	Date of Coverage
	Secondary Policy Holder is: <input type="checkbox"/> Patient <input type="checkbox"/> Responsible Party				
	Secondary Insurance		Plan Number	Group Number	Date of Coverage
N E A R E S T R E L A T I V E	Emergency Contact Last First Middle				
	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				
	Address				
	City		State	Zip Code	
	Phone HOME:	CELL:	WORK:		
Relationship to Patient					
How were you referred to our office? <input type="checkbox"/> Newspaper <input type="checkbox"/> Brochure <input type="checkbox"/> Friend/Family <input type="checkbox"/> Physicians Office <input type="checkbox"/> Attended Lecture <input type="checkbox"/> Insurance <input type="checkbox"/> Phone Book <input type="checkbox"/> Current Patient					

- I authorize direct payment of surgical/medical benefits to St. John Center for Wellness and Family Medicine.
- Co-Payments and charges for services that are not covered by my insurance company are due at the time of the office visit. I understand that I am financially responsible for any balance not covered by my insurance.
- I authorize St. John Center for Wellness and Family Medicine to release any incidental information that may be necessary for either medical care or in the processing of applications for financial benefit.
- I certify that the information given by me in applying for payment is correct. I authorize the payment of authorized benefits on my behalf. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

St. John Center for Wellness and Family Medicine
PATIENT PHI RELEASE FORM

I, _____, under any circumstances hereby authorize the
(Please Print—Patient/Guardian)
release of medical information to the following as indicated below.

Information may be released to the following:

Spouse _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Children _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Children _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Children _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parent(s) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Family Members: (Please list)

Caregivers: (Please list)

Other Physicians: (Please list)

Cardiologist:

Gynecologist:

GI:

Ophthalmologist:

Podiatrist:

Other:

Pick up of:

Prescriptions and/or samples for medications Yes No

To inquire about an appointment, last exam date,
or to make or cancel an appointment Yes No

May we leave a message on answering machine, or
with someone at home telephone number Yes No

Patient/Guardian Signature

Date

ASCENSION ST. JOHN CENTER FOR WELLNESS

18303 E. Ten Mile Road Suite 500 Roseville, MI 48066 Phone: 586.498.5160

P _____

ADULT HISTORY FORM

*Instructions: Please fill out as completely as possible. All information will be kept confidential.
BE SURE TO COMPLETE ALL PAGES OF THIS FORM.*

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/____

MEDICATION ALLERGIES

i.e. Penicillin, Sulfa, Aspirin I.V. Dye, etc.

ALLERGIC TO: _____	REACTION: _____
ALLERGIC TO: _____	REACTION: _____
ALLERGIC TO: _____	REACTION: _____
ALLERGIC TO: _____	REACTION: _____

MEDICATIONS

Please list all medications that you are now taking; **including those that you buy without a doctor's prescription** such as aspirin, cold tablets, vitamins and herbs. Use a separate sheet if needed.

MEDICATION	DOSE (HOW MUCH)	FREQUENCY TAKEN	MEDICATION	DOSE (HOW MUCH)	FREQUENCY TAKEN
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day
		____ Times/Day			____ Times/Day

ASCENSION ST. JOHN CENTER FOR WELLNESS

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P _____

PHARMACY INFORMATION

Pharmacy Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

IMMUNIZATION HISTORY

Immunizations	Recent Date	Immunizations	Recent Date
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	
<input type="checkbox"/> Flu Shot		<input type="checkbox"/> Tdap (Tetanus and Pertusis)	
<input type="checkbox"/> Gardasil/HPV		<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> Zostavax (Shingles)	
<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Meningococcus			

SURGICAL HISTORY

Surgery	Reason	Hospital	Year

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH
Grandmother (paternal)	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Grandfather (paternal)	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Grandmother (maternal)	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Grandfather (maternal)	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Father	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Mother	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Brother/Sister	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Brother/Sister	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:
Other: _____	Y/N		<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other:

ASCENSION ST. JOHN CENTER FOR WELLNESS

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P _____

SOCIAL HISTORY

Education: Less than 8th grade High School 2 Year College 4 Year College
 Post graduate

Marital status: Married Single Divorced Separated Widowed Domestic Partner

Exercise Level: None (No exercise) Occasional exercise Moderate exercise High level exercise

Caffeine: None Moderate Heavy # of cups/cans per day? _____

Alcohol: Do you drink alcohol? Yes No

If Yes, how often? Occasionally less than 3 times a week greater than 3 times a week

How many drinks per week? _____

Tobacco: Do you use tobacco? Yes No

If not currently, did you ever use tobacco? Yes No

Cigarettes - _____ pks./day

Chew - _____ / day

Cigars - _____ / day

of years _____

Or year quit _____

Drugs: Do you currently use recreational or street drugs? Yes No

If yes, list:

CURRENT SPECIALTY CARE

List all the doctors you see at least once a year:

Doctor	Specialty

PAST MEDICAL HISTORY

Please check all that apply that have been diagnosed by a doctor:

<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Leg/Foot Ulcers
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Has Pacemaker	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Blood Clots (or DVT)	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Polio
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hiatal Hernia or Reflux Disease	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Claustrophobic	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Reflux or Ulcers
<input type="checkbox"/> Diabetes – Insulin	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes – Non-Insulin	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Overactive Thyroid	<input type="checkbox"/> Other _____

SEXUAL HISTORY: I would rather discuss this with my caregiver in person.

(The purpose of these questions is to determine your risk factors)

Are you currently sexually active? Yes No Your sex partners are: Male Female Both

Do you currently have more than 1 partner? Yes No

Do you use condoms Yes No Other Birth Control Method Used _____

Have you had more than four sex partners in your lifetime? Yes No

Any history of sexually transmitted disease? Yes No If yes, what disease? _____

Interested in being screened for STI's? Yes No

Are you now or have you ever been physically or sexually abused? Yes No

FEMALES ONLY

Last PAP Smear: _____ Abnormal

Last Mammogram: _____ Abnormal

Age at first period: _____ Date of last period or age of menopause: _____

Total number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Number of c-sections: _____

(Check off all that apply)

Bleeding between periods

Hot Flashes

Heavy periods

Breast Lump or nipple discharge

Extreme menstrual pain

Painful intercourse

Vaginal itching, burning, or discharge

Wake in the night to go to the bathroom

REVIEW OF SYSTEMS

Please Check all that apply?

Allergic/Immunologic

- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular

- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional

- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (____ lbs)
- Weight Loss (____ lbs)

Eyes

- Dry Eyes
- Irritation
- Vision Change
- Date of Last Exam: _____

Ears/Nose/Mouth/Throat

- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds

- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine

- Fatigue
- Increased Thirst/Hunger/Urination

Gastrointestinal

- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic

- Easy Bruising/Bleeding
- Swollen Glands

Integumentary (Skin)

- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions

- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal

- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological

- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric

- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in a Relationship
- Mania
- Sleep Problems

Respiratory

- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

HOW DID YOU HEAR ABOUT US?

Please check all that apply

- Friend (name optional) _____
- Family (name optional) _____
- Other Physician (name optional) _____
- Sign or Building
- Yellow Pages
- Newspaper
- Physician Referral Line
- Hospital Website or Physician Directory
- Health Insurance Directory (type of insurance) _____
- Physician Practice Website
- Radio Advertisement
- Television or Cable Advertisement
- Radio Health Update Segment
- Saw physician as a speaker (name of event) _____
- Met the physician at the hospital as a health system employee
- Postcard Mailer to my home
- Other: _____