

Deborah Hartmann, M.D.
Stephanie Paluda, M.D.
Jill Page, M.D.
Kristen Wuckert, M.D.
Caprice McGrail, M.D.

Account No.: _____

Today's Date: _____

PATIENT INFORMATION

Please Print

Last Name First Name MI Birth Date Sex

Address City State Zip () Phone

Marital Status

Social Security Number Driver License Number

Single _____ Married _____
Divorced _____ Widowed _____
Seperated _____

() _____
Cell Phone

Religious Preference

EMPLOYER INFORMATION

Employer Occupation () Phone

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Last Name First Name MI Birth Date Sex

Social Security Number Employer () Employer Phone

RESPONSIBLE PARTY ADDRESS (IF DIFFERENT FROM PATIENT'S)

Address City State Zip () Phone

EMERGENCY CONTACT

Name, Address and Telephone Number of Emergency Contact or Nearest Relative **NOT** Living with You:

Address City State Zip () Phone

FOR ALL PATIENTS

I agree that I shall be legally responsible for any medical or surgical charge insured in excess of any hospitalization or health insurance that might be applicable.

I assign payment of authorized benefits to Mission OB/GYN, P.C. on my behalf for services rendered through Mission OB/GYN, P.C. I understand that I am responsible for the charges not covered by my policy.

RELEASE OF INFORMATION

I authorize Mission OB/GYN, P.C. to release any medical information required by my health insurance company to process a claim.

CONSENT TO TESTING

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues, or products may be obtained and that tests will be performed upon such fluids, tissue, and products, and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS), I will be counseled by my physician and I will be given the choice of consenting in writing to such testing. I have been informed that my written consent to testing for HIV antibody or other communicable diseases is not required by law in situations where a health care provider sustains an exposure to my blood or body fluids.

Witness

Signature of Patient or Legally Authorized Representative

FOR MEDICARE PATIENTS ONLY

I request payment of authorized Medicare benefits to either myself or Mission OB/GYN, P.C. on my behalf for services rendered through Mission OB/GYN, P.C. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

Patient's Signature

MISSION OBGYN

Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

MISSION OBSTETRICS &
GYNECOLOGY, P.C.
11300 E. THIRTEEN MILE RD.
STE. 4A
WARREN, MICHIGAN 48088-2500

I, _____, have received a copy of _____'s Notice of
Patient Name Practice Name
Privacy Practices.

Signature of Patient

Date

GYNECOLOGIC INTAKE HISTORY

NAME: _____ BIRTH DATE: ____/____/____ DATE: ____/____/____
 ADDRESS: _____
 CITY: _____ STATE/ZIP: _____
 HOME TEL: () _____ WORK TEL: () _____
 EMPLOYER: _____ INSURANCE: _____
 NAME OF SPOUSE/PARTNER: _____ REFERRED BY: _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	currently	past	Notes
1. Constitutional			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
2. Eyes			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
3. ENT/Mouth			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
4. Cardiovascular			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
5. Respiratory			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
6. Gastrointestinal			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
7. Genitourinary			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
8. Musculoskeletal			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
9. Skin/breast	Currently	Past	
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	

REVIEW OF SYSTEMS CONTINUED

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
Neurological	Currently	Past	Notes
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
12. Endocrine			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic/Lymphatic			
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic/Immunologic			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PAST HISTORY

MAJOR ILLNESSES		Yes	No			Yes	No
Asthma				Cancer			
Pneumonia				Ulcers			
Chronic Lung Disease				Depression/anxiety			
Kidney infections/stones				Anemia/Blood transfusions			
Tuberculosis				Seizures/convulsions/epilepsy			
Venereal Disease				Bowel trouble			
Heart Trouble/murmur				Glaucoma			
Diabetes				Arthritis/joint pain			
High Blood Pressure				Fracture			
Stroke				Hepatitis/Yellow jaundice			
Rheumatic Fever				Thyroid Disease			
OPERATIONS/HOSPITALIZATIONS							
Reason		Date		Reason		Date	
INJURIES/ILLNESSES							
Type		Date		Type		Date	
LAST IMMUNIZATION OR TEST							
		Date				Date	
Tetanus				Pneumonia			
Flu Shot				TB Skin Test			
OB/GYN HISTORY							
		Number				Number	
Births				Abortions			
Miscarriages				Living children			
CURRENT MEDICATIONS							
Drug Name		Dosage		Drug Name		Dosage	

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits					
Smoking	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Packs per day _____
Alcohol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Years _____
Drug Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Drinks per day _____
Seat Belt Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Drinks per week _____
Regular Exercise	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Personal Profile					
Marital Status	Married	<input type="checkbox"/>	Single	<input type="checkbox"/>	Widowed <input type="checkbox"/>
					Divorced <input type="checkbox"/>
Number of Living Children	_____				
Number of people in household	_____				
School Completed	High School	<input type="checkbox"/>	College	<input type="checkbox"/>	Graduate Degree <input type="checkbox"/>
					Other <input type="checkbox"/>
Current or most recent job	_____				

Completed by: Patient Office Nurse Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Subsequent Review of History

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____