PATIENT HISTORY

Name_____ Date_____

Allergies_____ Age_____ Birth Control_____

Referred By_____

Other Doctor (s) Patient Sees:
Dr. Name_____Specialty_____

Dr. Name_____Specialty_____

Dr. Name_____Speciality_____

Reason (s) For Your Visit:

1._____

2._____

3._____

Tell Us About Your Reason (s) (Symptoms) For Your Visit:

1._____

2._____

3._____

Prescriptions You Are Presently Taking:

	MEDICATION NAME	DOSE & FREQUENCY TAKEN	PRESCRIBING DOCTOR
1.			
2.			
3.			
4.			
5.			

Vitamin, Mineral, Herbal or Nutritional Supplement Presently Taken:

	SUPPLEMENT NAME	DOSE	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			

PATIENT HISTORY

NAME: _____ **DATE:** _____ **AGE:** _____

ALLERGIES: _____

FAMILY HISTORY:

Please indicate whether **immediate relatives** (parents, siblings, grandparents, aunts/uncles, cousins, or children) have or have died from any of the following:

Cancer:	Relationship	Age @ Diagnosis
Breast		
Ovarian		
Uterine		
Colon		
Other		

Other Family History:	Relationship	Age @ Diagnosis
Hypertension/Blood Pressure		
Mental Illness		
Heart Attack		
Diabetes		
Stroke		
Osteoporosis		
Alzheimer's Disease		

PERSONAL HISTORY/HEALTH STATUS:

Mark "C" for current problem; Mark "P" for past problem:

BREAST	
Lump	
Discharge	
Pain	
HEART/LUNG	
Chronic Cough	
Shortness of Breath	
Night Sweats	
Chest Pain/Pressure	
Palpitation/Fluttering	
Swollen Ankles	

EXTREMITIES	
Arthritis, Joint Pain	
Cramps in Legs	
Varicose Veins	
Blood Clots in Legs	
KIDNEY/BLADDER/ GENITALS	
Albumin or Sugar in Urine	
Blood or Pus in Urine	
Kidney or Bladder Infection	
Getting up at Night to Urinate (____ Times)	
Discharge, Leakage (Pad "Y" or "N"	

NEURO & PSYCHIATRIC	
Frequent Headaches	
Fainting Spells	
Convulsions	
Dizzy Spells	
Depression or Anxiety	
Suicidal Thoughts	
NECK	
Thyroid Disease	
Lump	
Pain or Stiffness	

GENERAL/ ENDOCRINE	
Back Pain	
Abnormal Thirst	
Unable to Sleep	
Acne	
Unusual Fatigue	
Skin Changes	
Abnormal Hair Growth	
Night Sweats/Hot Flash/Flush	
Pain with Intercourse	
Vaginal Dryness	
Mood Swings	
Decrease in Sexual Desire	

INTESTINAL	
Loss of Appetite	
Abdominal Swelling	
Black Tarry Stool	
Nausea or Vomiting	
Pain in Abdomen	
Gallbladder Trouble	
Belching or Bloating	
Change in Bowel Habits	
Constipation	
Diarrhea	

Do you consider your health to be: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Monthly Breast Exams ❑ Yes ❑ No

Regular Exercise ❑ Yes ❑ No Type/Frequency _____

Tobacco Use ❑ Yes ❑ No If Yes or Quit, form/amount For how long? _____

Caffeine-Containing Beverages (coffee, tea, cola) ❑ Yes ❑ No If Yes, how many cups per day? _____

Alcohol ❑ Yes ❑ No Type:_____How much?_____How often? _____

Street Drugs ❑ Yes ❑ No Type:_____How much?_____How often? _____

History of Mental Health Issues: ❑ Yes ❑ No If Yes, state type _____

History of Sexually Transmitted Disease (STD) – enter "Y" or "N"

Chlamydia _____ HPV/Warts _____ Gonorrhea _____ Herpes _____ Other (type) _____

Do you plan pregnancy in the near future? ❑ Yes ❑ No

Are there any babies born with birth defects, hereditary, or genetic diseases in your family or your husband's? ❑ Yes ❑ No

Type _____

Sexual Orientation: ❑ Heterosexual ❑ Homosexual ❑ Bisexual Number of Sexual Partners (lifetime) _____

Are you sexually active? ❑ Yes ❑ No Age at First Intercourse_____Method of Contraception _____

Have you lost or gained weight recently? ❑ Yes ❑ No Usual Weight Range_____

Have you ever been hit, slapped kicked, or otherwise physically hurt by someone? ❑ Yes ❑ No

Have you ever been forced to have sexual relations when you did not want to? ❑ Yes ❑ No Within the last 12 months? ❑ Yes ❑ No

_____

Physician Signature Date

Patient Information Sheet
True Gynecology

TODAYS DATE_____

YOUR PRIMARY CARE PHYSICIAN_____

ALLERGIES_____
_____
_____

NAME_____DOB _____SS #_____

ADDRESS_____CITY_____STATE_____ ZIP_____

WINTER/SUMMER ADDRESS_____

EMAIL ADDRESS_____

MARITAL STATUS: S W D M PHONE: H #_____ CELL #_____

YOUR EMPLOYER_____OCCUPATION_____WORK #_____

SPOUSE'S NAME_____SS# _____

SPOUSE'S EMPLOYER_____WORK #_____

EMERGENCY CONTACT: NAME_____PHONE # _____

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT. I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO THE REFERRING, AND FAMILY PHYSICIANS, AND TO MY INSURANCE COMPANY IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I ACKNOWLEDGE FULL RESPONSIBILITY FOR SERVICES RENDERED BY MY PHYSICIAN. I UNDERSTAND THAT PAYMENT FOR THOSE SERVICES IS DUE AT THAT TIME, UNLESS OTHER DEFINITE FINANCIAL ARRANGMENTS HAVE BEEN MADE. INSURANCE CLAIMS WILL BE SUBMITTED FOR ME FOR COVERED SERVICES ONLY, AND ONLY TO THOSE COMPANIES WITH WHICH OUR PRACTICE PARTICIPATES. WE RESERVE THE RIGHT TO SEND YOUR ACCOUNT TO A COLLECTION AGENCY FOR ANY DELIQUENT BALANCE, INCLUDING FEES INCURRED BECAUSE OF THIS ACTION, AND INCLUDING BUT NOT LIMITED TO COURT COSTS, AND COLLECTION TRASNFER FEES. MY SIGNATURE REPRESENTS MY AGREEMENT TO THESE TERMS. I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT/ THE ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

DATE_____ **SIGNATURE**_____

MICHIGAN LAW REQUIRES PHYSICIANS TO ADVISE PATIENTS ABOUT THEIR RIGHT TO CREATE AN ADVANCE DIRECTIVE.

YES NO I WOULD LIKE A COPY OF THE ADVANCE DIRECTIVE. **INITIALS**_____

PRIVACY POLICY
I WOULD LIKE TO REQUEST THAT THE FOLLOWING DESIGNATED PERSON BE GIVEN ACCESS TO MY RECORDS AND/OR MEDICAL CONDITION, ALLOWING THE PHYSICIAN AND STAFF TO DISCUSS PERSONAL, FINANCIAL, MEDICAL AND/OR CHANGES IN MEDICATION OR TREATMENT IF I AM UNABLE TO BE REACHED.

NAME AND RELATIONSHIP_____

MAY WE LEAVE A MESSAGE REGARDING APPOINTMENT REMINDERS, BALANCES AND/OR TEST RESULTS

ON YOUR CELL_____ HOME LINE_____WORK LINE_____ (PLEASE CHECK & SIGN BELOW)

PATIENT SIGNATURE_____

True Gynecology, PLLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, [name of patient]_____, acknowledge and agree that I have received and or reviewed the Notice of Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that the above stated notice is posted in the office where I can review it if desired.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative Date

_____ _____
Print Name of Legal Representative Relationship to Patient

I understand that this office participates in the PCMH Specialist program, and my information may be shared, as appropriate with other physicians participating in PCMH if they are involved in my care.

_____ _____
Patient Signature Date

FOR CLINIC USE ONLY:

True Gynecology made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice Of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

_____

_____

_____