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 or 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,

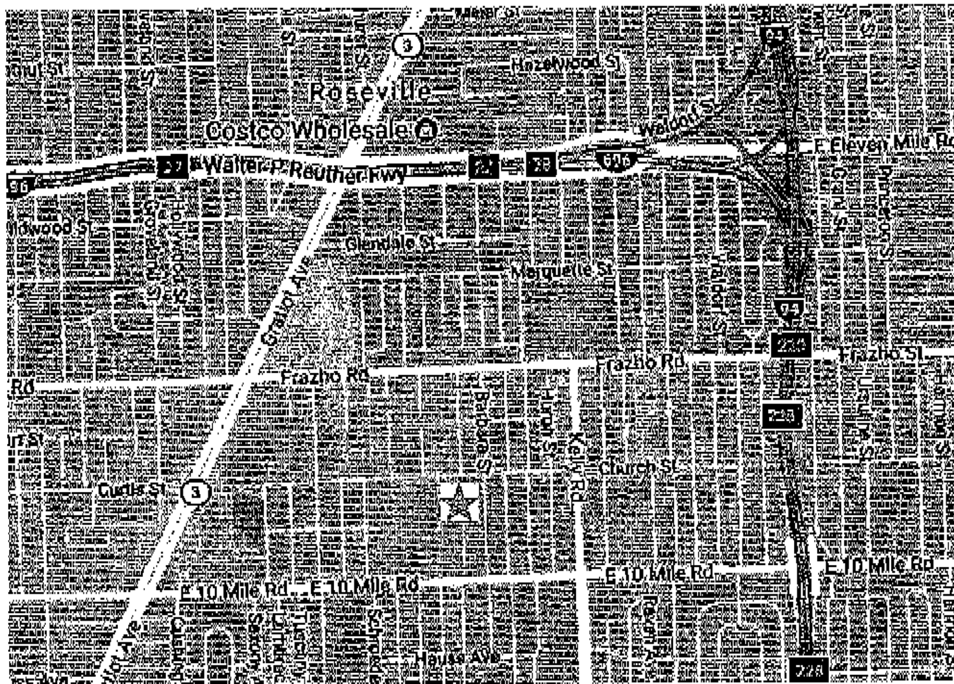
St John Center for Wellness and Family Medicine Staff

4/08

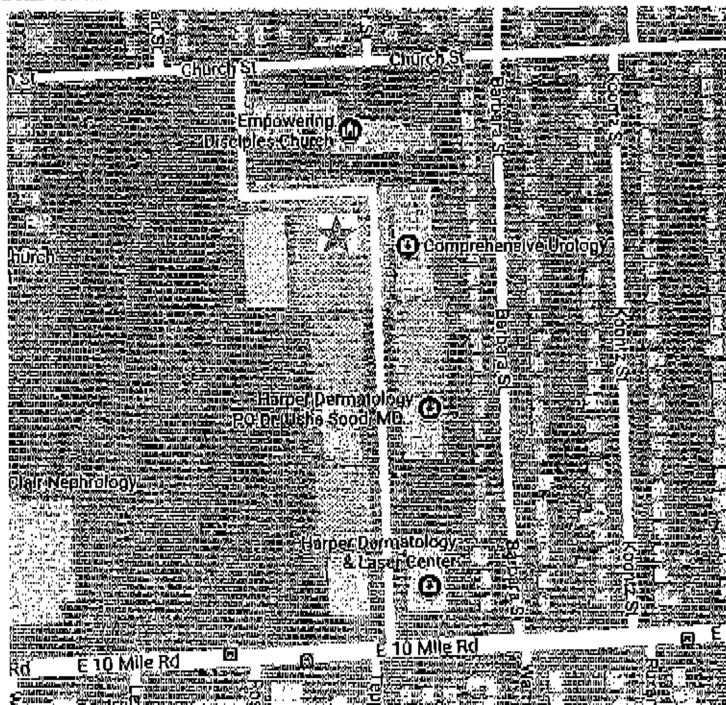
To come from I-94:
Get off at Ten Mile Rd. exit and head West towards Gratiot. We will be on the North (right) side on Ten Mile in the Pointe East Office Complex. Once in the complex we will be located at 18303 Suite 500, which is the last building on the left hand side.
Phone # 586-498-5160

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

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.

AUTHORIZATION FOR TREATMENT OF A MINOR

Name of Child/Children	Date of Birth	Allergies

Because the above named child/children are below the age of consent, I/We designate the individual(s) below to authorize any care, including diagnostic procedures and medical treatment, as may in their personal judgment be deemed necessary or beneficial for the time period indicated when I/We are unavailable to provide consent.

Authorized Individuals	Phone Number	Relationship to Child	Date Restrictions

Father ____________________ Employer ____________________
Home Phone ____________________ Work Phone ____________________
Address ____________________ Pager ____________________

Mother ____________________ Employer ____________________
Home Phone ____________________ Work Phone ____________________
Address ____________________ Pager ____________________

Legal Guardian ____________________ Employer ____________________
Home Phone ____________________ Work Phone ____________________
Address ____________________ Pager ____________________

Patient's Home Address ____
Street City State Zip

Home Phone ____________________

Medical Insurance ____________________ Contract I.D. # ____________________

Father ____________________ Date __________ Witness __________ Date __________
Signature

Mother ____________________ Date __________ Witness __________ Date __________
Signature

Guardian ____________________ Date __________ Witness __________ Date __________
Signature

This authorization is valid for only six (6) months from date of signatures by parent/guardian.

Parental permission not required for treatment of pregnancy, STD., and HIV.

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 ________________________________ ❑ Yes ❑ No

Children ________________________________ ❑ Yes ❑ No

Children ________________________________ ❑ Yes ❑ No

Children ________________________________ ❑ Yes ❑ No

Parent(s) ________________________________ ❑ Yes ❑ No

Other Family Members: (Please list)

____

____

Caregivers: (Please list)

____

____

Other Physicians: (Please list)

Cardiologist: ________________________________

Opthomologist: ________________________________

Gynecologist: ________________________________

Podiatrist: ________________________________

GI: ________________________________

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

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

PATIENT

Name	Last	First	Middle
☐ Mr. ☐ Mrs. ☐ Ms.			
Address			
City	State	Zip Code	
Date of Birth	Sex ☐ M ☐ F	Marital Status ☐ Married ☐ Single ☐ Divorced	Social Security Number
Phone HOME:	CELL:	WORK:	
Occupation	Employer	E-MAIL	
Pharmacy Location/Pharmacy Phone Number			

RESPONSIBLE PARTY

Name	Last	First	Middle
Address			
City	State	Zip Code	
Date of Birth	Sex ☐ M ☐ F	Marital Status ☐ Married ☐ Single ☐ Divorced	Social Security Number
Phone HOME:	CELL:	WORK:	
Occupation	Employer	E-MAIL	
Primary Policy Holder is: ☐ Patient ☐ Responsible Party			
Primary Insurance	Plan Number	Group Number	Date of Coverage
Secondary Policy Holder is: ☐ Patient ☐ Responsible Party			
Secondary Insurance	Plan Number	Group Number	Date of Coverage

NEAREST RELATIVE

Emergency Contact	Last	First	Middle
☐ Mr. ☐ Mrs. ☐ Ms.			
Address			
City	State	Zip Code	
Phone HOME:	CELL:	WORK:	
Relationship to Patient			

How were you referred to our office? ☐ Newspaper ☐ Brochure ☐ Friend/Family ☐ Physicians Office ☐ Attended Lecture ☐ Insurance ☐ Phone Book ☐ 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: ____________

ASCENSION ST. JOHN CENTER FOR WELLNESS
18303 E. Ten Mile Road Suite 500 Roseville, MI 48066 Phone: 586.498.5160 **P**________

PEDIATRIC 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

PHARMACY INFORMATION

Name____

Address____

City__________________________State__________Zip__________

Phone______________________________________

IMMUNIZATION HISTORY

Immunizations	Recent Date	Immunizations	Recent Date
☐ Chicken Pox		☐ MMR (Measles, Mumps, Rubella)	
☐ Flu Shot		☐ Tdap (Tetanus and Pertusis)	
☐ Gardasil/HPV		☐ Tetanus	
☐ Hepatitis A		☐ Zostavax (Shingles)	
☐ Hepatitis B		☐ Pneumonia	
☐ Meningococcus			

SURGICAL HISTORY

Surgery	Reason	Hospital	Year

ASCENSION ST. JOHN CENTER FOR WELLNESS
18303 E. Ten Mile Road Suite 500 Roseville, MI 48066 Phone: 586.498.5160 **P**______________

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH
Grandmother (paternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Grandfather (paternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Grandmother (maternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Grandfather (maternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Father	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Mother	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Brother/Sister	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Brother/Sister	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:
Other:__________	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic Disease ☐ Heart Disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other:

ASCENSION ST. JOHN CENTER FOR WELLNESS
18303 E. Ten Mile Road Suite 500 Roseville, MI 48066 Phone: 586.498.5160 **P**________________

SOCIAL HISTORY

Has this child ever been hospitalized overnight? ☐ Yes ☐ No
☐ Reason/age________________________________

How many hours of TV/Computer/Video games per day: ☐ 0-2 hours ☐ 2-4 hours ☐ >4 hours ☐ N/A
Sleep Habits: Bed time______ Wake up time______ Sleeps all night? ☐ Yes ☐ No Naps 0 1 2 3
Sleeps where? ☐ Crib ☐ Toddler bed ☐ Bed ☐ Parent bed ☐ Own room/sibling room ☐ Parent room
Child currently lives:
☐ With mother/name______________________ ☐ Stepfather/name______________________
☐ With father/name______________________ ☐ Stepmother/name______________________
☐ With relative/name/relationship____
☐ With foster care/name__________________ ☐ Group home______________________
☐ Siblings in home/names/ages____
☐ Siblings not in homes/names/ages____
☐ Custody arrangements (ie visits father/mother, how often?______________________
WHO IS LEGAL GUARDIAN OF THIS CHILD?______________________
Current grade in school:_______ ☐ Preschool ☐ Home school ☐ Special Education ☐ Speech
Current performance in school: ☐ Above average ☐ Average ☐ Below Average
Did your child miss more than ten days of your usual activity last year due to illness? ☐ Yes ☐ No
Does anyone smoke in the child's home? ☐ Yes ☐ No
Does anyone smoke in the child's daycare? ☐ Yes ☐ No
Does anyone have problems with alcohol? ☐ Yes ☐ No
Does anyone use illegal drugs in the child's home? ☐ Yes ☐ No
Does child exercise regularly? ☐ Yes ☐ No How often?_____days/week
Types of exercise:____________________
Is child secured for car ride? ☐ Rear facing car seat ☐ Forward facing car seat
☐ Booster seat ☐ seatbelt/rear seat with shoulder harness
☐ Seat belt/shoulder harness front seat (over age 12-14)
Any guns in the home: ☐ Yes ☐ No If yes, are they locked up ☐ Yes ☐ No
Is child now or even been physically or sexually abused? ☐ Yes ☐ No
Is parent or caregiver a victim of abuse? ☐ Yes ☐ No
Does child wear helmet for biking/blading/boarding? ☐ Yes ☐ No

FEMALES ONLY
Age at first period:______________ Last menstrual period date: ______________
Periods occur every ________days Number of days flowing: ______________
Flow is ☐ regular ☐ irregular
Problems with periods? ☐ Cramps ☐ PMS
☐ Other/describe____________________

ASCENSION ST. JOHN CENTER FOR WELLNESS
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CURRENT SPECIALTY CARE

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

Doctor	Specialty

BIRTH HISTORY

Mom age at this child's birth?_____ ☐ Vaginal ☐ Cesarean/why________
Which pregnancy for mom for this child? ____________________
Weight at birth?________________ Weight at hospital discharge_________
Apgar score 1 minute____________ Apgar at 5 minutes______________

☐ Full term ☐ Early ________ weeks ☐ Late______weeks
Newborn complications? ☐ None, home with mother ☐ Days in hospital____
☐ Oxygen ☐ Ventilator ☐ IV ☐ Antibiotics
☐ Intensive Care ☐ Jaundice
Pregnancy complications? ☐ Premature labor ☐ Tobacco in pregnancy
☐ Premature birth ☐ Alcohol in pregnancy
☐ Gestational Disease ☐ Drug use in pregnancy
☐ High blood pressure
☐ Other_________________________________
Newborn feeding ☐ Breast/how long______________ ☐ Bottle________________

PAST MEDICAL HISTORY

Please check all that apply that have been <u>diagnosed</u> by a doctor:

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

ASCENSION ST. JOHN CENTER FOR WELLNESS
18303 E. Ten Mile Road Suite 500 Roseville, MI 48066 Phone: 586.498.5160 P____________

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

What are the main concerns that bring you to our office today?

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Do you have any concerns about your child's development, behavior, school performance, or other issues?

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Patient Signature____

Date_____/_____/_____

Reviewed by______________________________________**Pazuchowski/Whitmyer/Rayes**

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: ______________________________