

Mercy Clinic Family Medicine

HEALTH HISTORY

Please fill in as much as possible.



Your life is our life's work.

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Today's Date: _____
 Date of Last Physical Exam: _____
 Date of Last Dental Exam: _____

HABITS:

Alcoholic Beverages (#/week): _____
 Caffeine Beverages (#/day): _____
 Cigarettes (packs/day): _____
 Other Stimulants: _____
 Exercise: _____
 Use of Seat Belts (circle one): Always Sometimes Never

PAST MEDICAL PROBLEMS:

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

PERSONAL HISTORY: Illnesses - Please put a check mark on the line if you have ever had:

	YES		YES		YES
Pneumonia	_____	High/Low Blood Pressure	_____	Bladder Disease	_____
Pleurisy	_____	Kidney Disease/Stone	_____	Abnormal Thirst	_____
Anemia	_____	Albumin, Sugar, Pus in Urine	_____	Heart Disease	_____
Jaundice	_____	Arthritis/Rheumatism	_____	Rheumatic Fever	_____
Epilepsy	_____	Neuritis/Neuralgia	_____	Learning Disabilities	_____
Cancer	_____	Frequent Infections, Colds, or Sore Throats	_____	Emotional Problems	_____
Hives or Eczema	_____	Bursitis, Sciatica or Lumbago	_____	Nervous Breakdown	_____
Gout	_____	Polio or Meningitis	_____	Migraine Headaches	_____
Nephritis	_____	Sexually Transmitted Disease	_____	Hay Fever or Asthma	_____
Diabetes	_____			Any Other Disease	_____

Childhood Illnesses (list) _____

Female Problems (list) _____

HOSPITALIZATIONS AND SURGERIES (Give date, place and reason) **DO NOT INCLUDE CHILDBIRTH**

1. _____
 2. _____
 3. _____
 4. _____

PREGNANCY: # _____ THERAPEUTIC ABORTIONS _____ MISCARRIAGES _____ CHILDREN _____

FAMILY HISTORY	Age (If living) and illnesses	Age at Death	If Deceased, Cause -- If Known	Has any blood relative* ever had:	Yes	Who?
Father				Cancer		
Mother				Tuberculosis		
Brother/Sister				Diabetes		
				Heart Trouble		
				High Blood Pressure		
Husband/Wife				Stroke		
				Birth Defects		
				Asthma		
Son/Daughter						

* Include parents, grandparents, brothers, sisters, children.

WEIGHT: Present: _____ 1 Year Ago: _____ Ideal: _____ Height: _____

SYSTEMS: Do you now have or have you had:

GENERAL: Have Now Ever Had
 Fever, Chills, Fatigue _____
 Has there been any recent change in:
 Your Appetite _____
 Your Stools _____
 Regularity of Bowels _____

SKIN: Have Now Ever Had
 Dryness, Itching _____
 Rash, Change in Birth Marks _____

ENT: Have Now Ever Had
 Eye Disease, Injury, Impaired Sight _____
 Ear Disease, Injury, Hearing Loss _____
 Trouble with Nose, Sinuses, Mouth, Throat, Teeth, Gums _____
 Hay fever _____

HEAD AND NECK: Have Now Ever Had
 Fainting Spells _____
 Loss of Consciousness _____
 Seizures _____
 Paralysis, Tremor, Weakness _____
 Dizziness _____
 Frequent or Severe Headaches _____
 Depression, Anxiety, Emotional Problems _____
 Memory Loss _____
 Enlarged Nodes or Lumps _____
 Enlarged Thyroid or Goiter _____

WOMEN ONLY: Menstrual History
 Age at onset: _____ Regular: No _____ Yes _____
 Menstrual Cycle: Days (from start to start) _____
 Usual Duration: _____
 Pain or Cramps: No _____ Yes _____
 Date of Last Period: _____
 Any Contraceptive Method Used? _____
 What Type? _____
 Discharges/Sores? _____
 Abnormal PAP _____ Cryotherapy _____ Colposcopy _____

X-RAYS: Have you ever had X-rays of:
 Kidneys _____
 Chest _____
 Stomach or Colon _____
 Extremities _____
 Back _____

CHEST: Have Now Ever Had
 Chronic/Frequent Cough _____
 Chest Pain/Angina Pectoris _____
 Spitting up of Blood _____
 Night Sweats _____
 Shortness of Breath, Wheezing _____
 Palpitation/Fluttering Heart _____
 Swelling of Hands or Feet _____
 Breast Lumps _____

ABDOMEN: Have Now Ever Had
 Stomach Trouble/Ulcer Pain _____
 Indigestion, Nausea, Vomiting _____
 Liver/Gall Bladder Disease _____
 Hemorrhoids/Rectal Bleeding _____
 Constipation/Diarrhea _____
 Hernia _____

BACK AND EXTREMITIES: Have Now Ever Had
 Back Pain _____
 Joint Stiffness, Swelling _____

URINARY: Have Now Ever Had
 Blood in Urine _____
 Burning, Pain _____
 Increased Frequency _____
 Unable to Control Urine _____
 Kidney/Bladder Stones _____

MEN ONLY: Have Now Ever Had
 Prostatitis _____
 Testicular Pain _____
 Penile Discharge _____
 Infertility _____
 Premature Ejaculation _____
 Difficulty with Erection _____

TESTS/PROCEDURES: (Give Dates)
 Pap Test _____ Urine _____
 Vision _____ Blood _____
 Hearing _____ Transfusion _____
 TB _____ EKG _____
 Mammogram _____
 Other _____

IMMUNIZATIONS: (Indicate Date)

	#1	#2	#3	#4	#5
DPT					
Polio					
DT (Tetanus)					

M, M, R _____ Varicella _____ Other _____



Name: _____

Date of Birth: _____

Consent and Agreement Physician Services and Hospital Services

1. **Annual Consent for Services:** I consent to the services that may be performed by a Mercy Health (“Mercy”) physician or non-physician provider (“provider”) or facility. I understand I can withdraw this consent at any time. This consent and agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician’s office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location.
2. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Mercy’s Charge Description Master as of the date of treatment, unless I am entitled to pay a different amount under my (or the patient’s) health insurance plan or my (or the patient’s) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney’s fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.
3. **Assignment of Insurance Benefits:** I assign to Mercy, my physician or other non-Mercy healthcare professionals involved in my (or the patient’s) care my (or the patient’s) rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
4. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient’s) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient’s) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.
5. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
6. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Mercy may pursue corrective action.
7. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Consent and Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Mercy’s website.



Name: _____

Date of Birth: _____

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- 8. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of unusual value, Mercy is not responsible for the loss or damage to these items.
- 9. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.
- 10. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.
- 11. **Phone Calls:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages, even if I am charged for the call under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Mercy and its collection agencies may monitor and/or record any communication
- 12. **Notice to Mercy Co-workers:** As a co-worker employed by an entity owned or controlled by Mercy, I agree to payment of outstanding balances(s) due for medical services rendered to me, or any dependents for whom I am financially responsible, after all applicable insurance payments are received for such services. In the event I do not make reasonable attempts to resolve the outstanding balances, I understand Mercy may initiate payroll deduction, in accordance with Mercy's Co-worker Payroll Deduction Policy.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____ Time: _____



Your life is our life's work.

**Protected Health Information
Authorized Person(s)**

_____, _____ hereby authorize release of my
Print Patients Name **Date of Birth**

Protected Health Information for verbal discussion only of my care and treatment to the person(s) specified below:

_____	_____	_____
Print Name	Relationship to Patient	Phone Number
_____	_____	_____
Print Name	Relationship to Patient	Phone Number
_____	_____	_____
Print Name	Relationship to Patient	Phone Number

Note: This form does not give the above referenced person(s) permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed.
Exception: if the release is needed in emergency situations.

May we include you in the clinic or hospital directory? Yes No
Example: If you are in our clinic/hospital seeking treatment and a spouse or other family member calls to inquire if you are still there, can we say yes or no?

May we leave a message on an answering machine or voice mail? Yes No
Example: We may leave message reminders, scheduling changes or lab result notices on your answering machine. Would this be acceptable, yes or no?

May we leave a message for patient to return call? Yes No
Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this be acceptable, yes or no?

Note: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke any previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature Date

OR

Guardian or Personal Representative Relationship to Patient

Note: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to the Mercy Clinic where my medical records are kept.