Mercy Clinic Family Medicine
HEALTH HISTORY

Please fill in as much as possible.

Mercy

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.

NAME _____
BIRTH DATE _____

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

ALLERGIES: Are you allergic to any drugs? _____
LIST: _____
_____
_____

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

List Prescribed Medications:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

PAST MEDICAL PROBLEMS:
1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS:	Do you use these?	How often?
Aspirin	_____	_____
Tylenol	_____	_____
Vitamins	_____	_____
Laxatives	_____	_____
Sleeping Pills	_____	_____
Dietary Supplements	_____	_____

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,		Emotional Problems	_____
Hives or Eczema	_____	or Sore Throats	_____	Nervous Breakdown	_____
Gout	_____	Bursitis, Sciatica or Lumbago	_____	Migraine Headaches	_____
Nephritis	_____	Polio or Meningitis	_____	Hay Fever or Asthma	_____
Diabetes	_____	Sexually Transmitted Disease	_____	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. _____

PREGANACY: # _____ THERAPEUTIC ABORTIONS _____ MISCARRIAGES _____ CHILDREN _____

FAMILY HISTORY	Age (If living) and illnesses	Age at Death	If Deceased, Cause -- If Known
Father			
Mother			
Brother/Sister			
Husband/Wife			
Son/Daughter			

Has any blood relative* ever had:	Yes	Who?
Cancer		
Tuberculosis		
Diabetes		
Heart Trouble		
High Blood Pressure		
Stroke		
Birth Defects		
Asthma		

* 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	_____

IMMUNIZATIONS: (Indicate Date)

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

M, M, R _____ Varicella _____ Other _____

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 _____

Mercy

Name:_____

Date of Birth:_____ MRN#: _____ CSN: _____

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 my (or the patient's) rights under all insurance and benefit plan documents and authorize direct payment to Mercy of all insurance and plan benefits payments for services provided by Mercy. By paying Mercy, 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.

Mercy

Name:_____

Date of Birth:_____ MRN#: _____ CSN: _____

Consent and Agreement
Physician Services and Hospital Services
Page 2

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.

Date:_____Time: _____Signature: _____

If signed by other than patient, indicate relationship: _____

Witness:_____ Date:_____Time:_____

Mercy

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.