**Mercy Clinic Family Medicine**

**HEALTH HISTORY**

Please fill in as much as possible.

**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,    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. __________________________________________________________________

**PREGNANCY:** # _______________ THERAPEUTIC ABORTIONS _______________ MISCARRIAGES _______________ CHILDREN _______________


<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
<th>Age (If living) and illnesses</th>
<th>Age at Death</th>
<th>If Deceased, Cause -- If Known</th>
<th>Has any blood relative* ever had:</th>
<th>Yes</th>
<th>Who?</th>
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</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
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<tr>
<td>Mother</td>
<td></td>
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<td>Tuberculosis</td>
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<td>Brother/Sister</td>
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<td></td>
<td>Diabetes</td>
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<td>Husband/Wife</td>
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<td>Heart Trouble</td>
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<td>Son/Daughter</td>
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<td></td>
<td>High Blood Pressure</td>
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<td>Stroke</td>
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<td></td>
<td>Birth Defects</td>
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<td></td>
<td></td>
<td></td>
<td>Asthma</td>
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* Include parents, grandparents, brothers, sisters, children.
## WEIGHT:

- Present: ____________
- 1 Year Ago: ____________
- Ideal: ____________
- Height: ____________

## SYSTEMS: Do you now have or have you had:

### GENERAL:

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

### SKIN:

- Dryness, Itching
- Rash, Change in Birth Marks
- Have Now: ________
- Ever Had: ________

### CHEST:

- Chronic/Frequent Cough
- Have Now: ________
- Ever Had: ________
- 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:

- Stomach Trouble/Ulcer
- Pain
- Indigestion, Nausea, Vomiting
- Liver/Gall Bladder Disease
- Hemorrhoids/Rectal Bleeding
- Constipation/Diarrhea
- Hernia

### ENT:

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

### HEAD AND NECK:

- 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
- Have Now: ________
- Ever Had: ________

### URINARY:

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

### 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:

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<th>#4</th>
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<tbody>
<tr>
<td>DPT</td>
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<tr>
<td>Polio</td>
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<tr>
<td>DT (Tetanus)</td>
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<tr>
<td>M, M, R</td>
<td>Varicella</td>
<td>Other</td>
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### TESTS/PROCEDURES: (Give Dates)

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<tr>
<th>Pap Test</th>
<th>Urine</th>
<th>Vision</th>
<th>Blood</th>
<th>Hearing</th>
<th>Transfusion</th>
<th>TB</th>
<th>EKG</th>
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<tr>
<th>Mammogram</th>
<th>Other</th>
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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.
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: ______________________

Name: __________________________________________  Date of Birth: ____________  MRN#: ___________  CSN: ___________
Your life is our life’s work.

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**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:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Relationship to Patient</th>
<th>Phone Number</th>
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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.