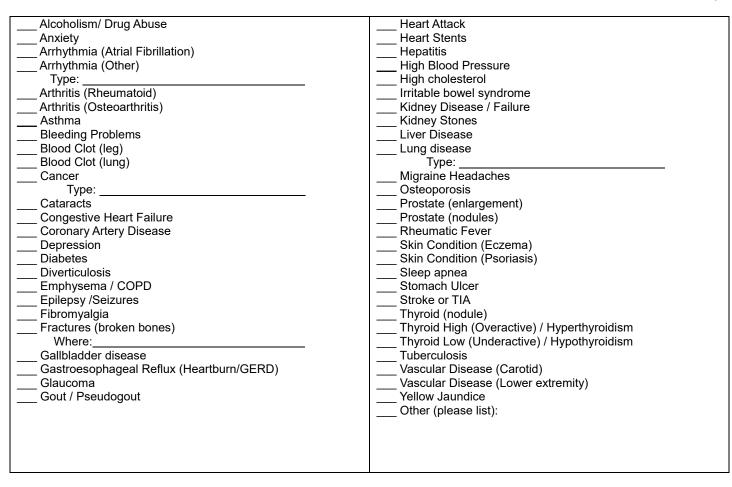
MEDICAL HISTORY QUESTIONNAIRE

James M. Robbins, M.D. Felicia A. Ivascu, M.D. Mario Raul Villalba, M.D. Jimmi Mangla, MD Wesley Barnes, M.D.

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General Information						
Patient's Name:						Date:
Birth Date:	Age:	Sex:	Male	Female	Social Security Numb	er:
Address:						
Home Phone:		Business F	Phone:			
Cell Phone:		Email Addr	ess:			
Marital Status: Marrie	d Single Divorce	d Widowe	d Sep	parated		
Name of Spouse:		Bir	th Date	ə:		
Spouse's Employer:						
Patients Occupation:	. <u></u>					
Position:				Employer:		
Address:						
Dhanai						
Insurance Company:						
Family Physician and	d/or Primary Healt	h Care Pro	vider:			
Doctor/Other:				Phone: _		
Address:				City:		
□ Yes □ No					·	nsult with them as necessary?
Name of Referring Pl	hysician:					
Is this visit injury relate If yes, please chec			Date c	of Injury:		
PLEASE	E BRING INSURAN	ICE CARD	s то т	HE FRONT	WINDOW TO BE COPI	ED

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?



SURGICAL HISTORY: Please check off any procedure or surgeries.

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Aneurysm Repair			
Appendectomy (appendix			Circle: Laparoscopic
removal)			
Back Surgery			
Bariatric			
Biopsy			
Breast Biopsy			Circle: Right Left Both
Breast Surgery			Circle: Right Left Both
Cardiac Bypass (CABG)			
Carotid Endarterectomy			
(cleaned out)			
Cataract			
Colonoscopy			
Coronary Stent			
EGD (Stomach Endoscopy)			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery (other than			
coronary bypass / CABG)			
Hip Fracture			Circle: Right Left Both
Hip Replacement			Circle: Right Left Both
Hysterectomy (total, including			
ovaries)			
Hysterectomy (partial, ovaries			
left)			

Knee Arthroscopy (scope)	Circle: Right Left Both
Knee Replacement	Circle: Right Left Both
Neck Surgery	
Ovary Ligation ("Tubal")	
Ovary Removal	Circle: Right Left Both
Prostate Surgery	Circle: Removed TURP
Vascular Bypass Graft in Legs	Circle: Right Left Both
Vasectomy	
Vein Stripping	
Other (please list):	

SOCIAL HISTORY:

Tobacco Use

Smoke cigarettes: Never No Yes
(If you never smoked please go to alcohol use question now)
Quit date:
How many years did you smoke?
Approximately how many packs a day did you smoke?
Current smoker: Packs/day: # of years:
Other tobacco: □ Pipe□ Cigar □ Chew
Alcohol Use
Do you drink alcohol? Yes No
of drinks/week:
Drug Use Do you use marijuana or recreational drugs? □ Yes □ No
Other Please list the people you currently live with:
Can you walk up one flight of stairs without difficulty? □ Yes □ No
What is your occupation? Does it involve any lifting? _ Yes _ No
Do you feel safe in your home? □ Yes □ No

FAMILY HISTORY: Indicate which relative has had the following diseases (parents and siblings are most important).

Adopted – \Box Yes \Box No If yes and you do not know your family history skip this section and continue to medications.

Disease	Yes	Relative
Alzheimer's		
Arthritis		
Autoimmune Disease		
Bleeding or Clotting Disorder		
Cancer (please list type with		
relative)		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Reaction to Anesthesia		
Other		

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there. □ TAKING NO MEDICATIONS

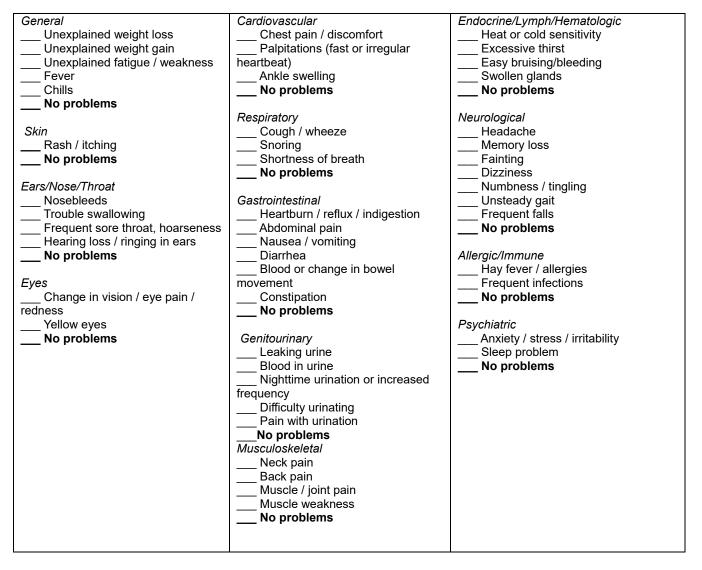
Name of Medication	Dose (e.g., mg/pill)	How Often?

ALLERGIES: Allergies or intolerance to medications (include type of reaction):

Latex allergy?

□ Yes 🗆 No

REVIEW OF SYSTEMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.



<u>Authorization for Release of Information to Family Member or Friend</u> <u>Without Power of Attorney</u>

I _____(patient), hereby give the following person

or person's authorization to obtain information regarding my:

Confirm appointments and leave messages
 Lab Work / Test Results
 Medical Records Information
 Billing Information
 All of the above

Person 1:	_Relationship
Person 2:	_Relationship
Person 3:	_Relationship
Person 4:	_Relationship
Person 5:	_Relationship

Patient Signature: Date	
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Notice of Privacy Practices Acknowledgement

James M. Robbins, M.D. Felicia A. Ivascu, M.D. Mario Raul Villalba, M.D. Jimmi Mangla, M.D. Wesley Barnes, M.D.

> 3535 W. 13 Mile Rd. Suite 501 Royal Oak, MI 48073 Phone (248) 288-1130/ Fax (248) 288-5931

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.

Date:

• Conduct normal healthcare operations such as assessments and physician certifications.

I have received read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name	
Relationship to Patient if Unable to Sign_	
Signature:	

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below: