ATTENTION ADULT PATIENTS

PLEASE DO NOT BRING YOUR CHILDREN TO YOUR APPOINTMENT.

THIS CAUSES TOO MUCH MENTAL EXCITEMENT FOR OUR NEUROLOGICAL PATIENTS.

LOUD NOISES AND STIMULUS CAN HAVE DETREMENTAL AFFECTS ON OUR SEIZURE PATIENTS.

THIS IS WHY WE HAVE SEPARATE ADULT AND PEDIATRIC DAYS.

IF YOU DO BRING YOUR CHILDREN YOU MAY BE ASKED TO HAVE SOMEONE WAIT WITH THEM IN THE HALL UNTIL YOUR APPOINTMENT IS OVER.

THANK YOU!

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF08139 (R 8/14)

PATIENT HEALTH HISTORY FORM

Covenant Neurosurgery
800 Cooper Ave., Ste. 8
Saginaw, MI 48602
Tel: (989) 752-1177
Fax: (989) 752-2923

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Social Security #: _____

Reason for Visit: _____

Please list all physicians you are under the care of:

Physician's Name: _____ Phone Number: _____

Physician's Name: _____ Phone Number: _____

Physician's Name: _____ Phone Number: _____

A. **This problem is the result of a(n):** *Check all that apply* Date of Injury: _____

☐ Motor Vehicle Accident ☐ Work Accident ☐ Accident

B. **Social History:** *Check all that apply*

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse Name _____

Smoking: ☐ I smoke _____ pack of cigarettes per day for _____ years.

☐ I never smoked. ☐ I don't smoke now, but I smoked _____ packs for _____ years on the past. (I quit smoking _____ years ago).

☐ I chew tobacco. ☐ I smoke cigars or a pipe.

Alcohol: ☐ I drink _____ (type and amount of alcohol)

☐ Daily ☐ 1 or More Times/Week ☐ 1 or More Times/Month ☐ 1 or More Times/Year

☐ I quit drinking alcohol _____ years ago.

☐ I never drink alcohol.

Illegal Drugs: ☐ I use _____ (type and frequency)

☐ I used _____ (type and frequency) in the past

☐ I never used illegal drugs.

C. **List Drug or Medication Allergies with type of Reaction** (Rash, Stop Breathing, Etc.)

☐ No known allergies

Medication	Reaction	Medication	Reaction

Have you had skin or other reactions to: *Check all that apply*

☐ Novocaine ☐ Tetanus Antitoxin ☐ Iodine

☐ IVP Dye ☐ Latex Rubber ☐ Shellfish

D. MAJOR ILLNESSES AND INJURIES ☐ **None**

E. Do you have any of the following medical problems? *Check all that apply*

	How Long?
☐ Cholesterol	
☐ Diabetes	
☐ High Blood Pressure	
☐ Cancer Where?_____	
☐ Stroke	
☐ Heart Trouble	
☐ Convulsions/Seizures/Epilepsy	
☐ MS	
☐ Parkinsons	
☐ Memory Loss	
☐ Headache	
☐ Dizziness	
☐ Other_____	

☐ **None of the Above**

F. SURGERIES/HOSPITALIZATIONS **YEAR** **COMPLICATIONS**

Have you ever had problems with anesthesia? ☐ Yes ☐ No

☐ **None**

G. Family Medical History:

Family Member	Alive/Dead	Age	Illnesses/Cause of Death
Father	☐ / ☐		
Mother	☐ / ☐		
Sister(s)	☐ / ☐		
	☐ / ☐		
Brother(s)	☐ / ☐		
	☐ / ☐		

H. CURRENT MEDICATIONS **DOSE** **HOW OFTEN**

Are any of your medications blood thinners? ☐ Yes ☐ No

☐ **I do not take any prescription/over the counter medications.**

I. Do you have any of the following? *Check all that apply*

GENERAL

- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Night Sweats
- ☐ **None**

EYES

- ☐ Wear Glasses/Contacts
- ☐ Eye Infections
- ☐ Eye Injuries
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ **None**

EARS/NOSE/THROAT/MOUTH

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Wearing Hearing Aides
- ☐ Ear Infections
- ☐ Balance Problems
- ☐ Sinus Infections
- ☐ Nose Bleeds
- ☐ Inability to Smell
- ☐ Sinus Headaches
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Bad Taste in Mouth
- ☐ Sore Throat
- ☐ Voice Change
- ☐ Swollen Glands in Neck
- ☐ **None**

HEART/CARDIOVASCULAR

- ☐ Chest Pain or Angina
- ☐ Irregular Pulse or Palpitations
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Swelling of Hands
- ☐ Swelling of Feet or Ankles
- ☐ Shortness of Breath with Walking/Lying Flat
- ☐ Leg Pain with Walking
- ☐ **None**

BREATHING/RESPIRATORY

- ☐ **None**
- ☐ Frequent Cough
- ☐ Chronic Cough
- ☐ Spitting up Blood
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Wheezing

STOMACH/BOWELS/GASTROINTESTINAL

- ☐ Loss of Appetite
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Heartburn
- ☐ Ulcer
- ☐ Gastritis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Pain with Bowel Movement
- ☐ **None**
- ☐ Liver Disease
- ☐ Rectal Bleeding or Blood in Stool
- ☐ Jaundice

GENITOURINARY

- ☐ Frequent Urination
- ☐ Burning with Urination
- ☐ Pain with Urination
- ☐ Blood in Urine
- ☐ Change of force of Stream with Urinating
- ☐ Kidney Stones
- ☐ Incontinence or Dribbling
- ☐ Sexual Difficulty
- ☐ Urinary Tract Infections

Males

- ☐ Testicle Pain
- ☐ Prostate Problems

Females

- ☐ Pain with Periods
- ☐ Irregular Periods
- ☐ Vaginal Discharge
- # of Pregnancies_____
- # of Miscarriages_____
- ☐ Currently Pregnant
- Date of last Menstrual Period_____
- ☐ **None**

MUSCLES AND BONES/MUSCULOSKELETAL

- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Weakness of Muscles
- ☐ Weakness of Joints
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Muscle Spasms or Cramps
- ☐ Difficulty Walking
- ☐ Coldness in Arms or Legs
- ☐ **None**

SKIN/BREAST/INTEGUMENTARY

- ☐ Rash
- ☐ Itching
- ☐ Varicose Veins
- ☐ Change in Skin Color
- ☐ Change in Hair or Nails
- ☐ **None**
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge

NEUROLOGICAL

- ☐ Frequent Headaches
- ☐ Lightheaded or Dizzy
- ☐ Tremors
- ☐ Convulsions/Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis
- ☐ Stroke
- ☐ Head Injury
- ☐ Speech Problems
- ☐ Coordination Problems
- ☐ Face Weakness
- ☐ **None**

MENTAL/PSYCHIATRIC

- ☐ Confusion
- ☐ Memory Loss
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia
- ☐ **None**

GLANDS/ENDOCRINE

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Hormone Problems
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Skin becoming Dryer
- ☐ Heat or Cold Intolerance
- ☐ Change in Hat or Glove Size
- ☐ **None**

BLOOD/INFECTION HEMATOLOGIC/LYMPHATIC

- ☐ Slow to Heal after Cuts
- ☐ Bleeding Tendencies
- ☐ Bruises Easily
- ☐ Anemia
- ☐ Plebitis
- ☐ Past Transfusions
- ☐ Persistent Swollen Glands
- ☐ **None**

ALLERGIC/IMMUNOLOGIC

- ☐ Cancer Where _____ Treatment _____

List Food Allergies _____

List Environmental Allergies _____

(Dust, Pollen, Molds, Etc.)_____

- ☐ None

I certify that the above information is complete and correct to the best of my knowledge:

_____ _____

Name of Person Completing Form | Relationship to Patient

_____ _____

Signature of Person Completing Form | Date

Note: This is a confidential record and will be kept in our office. Information contained here will not be released to anyone other than your doctor without your authorization.

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

CONSENT/PATIENT INFORMATION

PF02996 (2/11)

PATIENT I.D. _____

Patient Full Legal Name: _____ Photo ID: y/n _____

Date of Birth: _____ Soc Sec #: _____ Patient Sex: _____ Male _____ Female

Address: _____ Marital Status: S / M / D / W

City, State, Zip: _____ Ethnicity: _____

Telephone: _____ Preferred Language: _____

Cell Phone#:(_____) _____ Race: White / Black / Hispanic / Asian / Other

Email Address: _____

Contact Person Other than Home: _____ Telephone #: (_____) _____ - _____

Patient Employer: _____ Employer Telephone: _____

Employer Address: _____ Date of Retirement: _____

Student:Full Time: _____ Part Time: _____ Parent/Guardian: _____

Family Doctor: _____ ReferringDoctor: _____

Pharmacy _____ Location: _____

BILL TO:Self___Parent/Guardian___Work comp___Auto___Insured Name & Date of Birth _____

Primary Insurance: _____ Secondary Insurance: _____

Spouse Name: _____ Spouse Employer: _____

Spouse Date of Birth: _____ Employer Address: _____

Spouse Soc. Sec. #: _____ - _____ - _____ Date of Retirement: _____

AUTHORIZATION FOR MEDICAL INSURANCE BENEFITS

1) I assign payment to be made on my behalf to Covenant Healthcare.
2) I also authorize Covenant Healthcare to furnish information necessary for claims processing to any insurance carrier concerning my illness and treatments.
3) A universal claim form will be completed to help expedite insurance carrier payment.
4) I understand that all professional services will be charged to the patient for insurance other than our participating carriers.
5) Payment of the account is the patient(s direct responsibility and I am responsible for any non-paid services.
6) Payment for services are due when rendered unless other arrangements have been made in advance with our billing staff.

_____ _____

Date Patient Signature/Guardian

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF08203 (R 12/04)

ACKNOWLEDGMENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT I.D.

I acknowledge, by signing below, that I have received a copy of the Covenant HealthCare **Notice of Privacy Practices**.

_____
Name

_____
Signature

Date:___/___/___

Covenant HealthCare Staff Use Only

Acknowledgment Received:_____/_____/_____

Reason Acknowledgment **was not** Received:

☐ I have previously received the Notice of Privacy Practices.

☐ Other, explain:

_____

_____

_____

Covenant HealthCare Staff _____
(Signature)

COVENANT
Neurosurgery

Authorization for Release of Information

This may include your spouse, children, siblings, caregiver, etc

Date:_____

I, _____, give Covenant Neurosurgery permission to release and/or discuss my medical information with the following people:

Name:_____

Relationship:_____Phone:_____

Name:_____

Relationship:_____Phone:_____

Name:_____

Relationship:_____Phone:_____

I, _____, give consent to the office listed above to identify themselves and leave messages on the answering machines/voice mails attached to the phone numbers I have listed as my contact numbers. I understand that the messages may include information on dates of future appointments and/or test results.

_____ _____ _____

Patient Signature * Date of Birth Date

_____ _____

Witness Date