St John Center for Wellness and Family Medicine
18303 Ten Mile Road, Roseville, Michigan 48066
Phone: 586-498-5160 Fax: 586-498-5199

Dear Patient,

Welcome to St. John Center for Wellness and Family Medicine. We are happy to assist you in promoting both you and your family's well being. We are extremely pleased with how so many of our families have been sharing the good news about our practice growth and our emphasis on personalized patient care. Our Providers and support staff are dedicated to making sure your experience in our office is one that you will feel good about for years to come.

To help us ensure that your first visit goes smoothly, please take a few minutes to fill out these registration and history forms completely. After completing the forms please return them to our office in the enclosed envelope, at least 1 week prior to your scheduled appointment date. Our caregivers feel very strongly that in order to make your appointment as rewarding as possible, they must be able to review your history **before** you arrive. This frequently takes 20-30 minutes. **Therefore, if the paperwork is not received prior to the day of your appointment, it will be cancelled.** It is of the utmost importance that you arrive 15 minutes prior to your appointment time to complete the registration process; any tardiness on your part will delay your appointment.

Lastly, please remember to bring the following with you to your appointment:

- Health history records
- Immunization records
- **ALL** current medications, vitamins and supplements – bring the bottles.
- Insurance cards
- Insurance co-pay (if there is a co-payment required by your insurance company contract each time you visit the office for any service. Payment is always expected at the time of service.)

If you have any questions concerning the forms or need to cancel or reschedule your appointment, please call (586) 498-5160.

Yours in Good Health,

St John Center for Wellness and Family Medicine Staff

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PATIENT REGISTRATION FORM

PATIENT

Name	**Last**	**First**	**Middle**
☐ Mr. ☐ Mrs. ☐ Ms.			
Address			
City	**State**	**Zip Code**	
Date of Birth	**Sex**	**Marital Status**	**Social Security Number**
	☐ M ☐ F	**☐ Married ☐ Single ☐ Divorced**	
Phone			
HOME:	**CELL:**	**WORK:**	
Occupation	**Employer**	**E-MAIL**	

RESPONSIBLE PARTY

Name	**Last**	**First**	**Middle**
Address			
City	**State**	**Zip Code**	
Date of Birth	**Sex**	**Marital Status**	**Social Security Number**
	☐ M ☐ F	**☐ Married ☐ Single ☐ Divorced**	
Phone			
HOME:	**CELL:**	**WORK:**	
Occupation	**Employer**	**E-MAIL**	
Primary Policy Holder is:	**☐ Patient**	**☐ Responsible Party**	
Primary Insurance	**Plan Number**	**Group Number**	**Date of Coverage**
Secondary Policy Holder is:	**☐ Patient**	**☐ Responsible Party**	
Secondary Insurance	**Plan Number**	**Group Number**	**Date of Coverage**

NEAREST RELATIVE

Emergency Contact	**Last**	**First**	**Middle**
☐ Mr. ☐ Mrs. ☐ Ms.			
Address			
City	**State**	**Zip Code**	
Phone			
HOME:	**CELL:**	**WORK:**	
Relationship to Patient			

How were you referred to our office? ☐ Newspaper ☐ Brochure ☐ Friend/Family ☐ Physicians Office ☐ Attended Lecture ☐ Insurance ☐ Phone Book ☐ Current Patient

- I authorize direct payment of surgical/medical benefits to St. John Center for Wellness and Family Medicine.
- Co-Payments and charges for services that are not covered by my insurance company are due at the time of the office visit. I understand that I am financially responsible for any balance not covered by my insurance.
- I authorize St. John Center for Wellness and Family Medicine to release any incidental information that may be necessary for either medical care or in the processing of applications for financial benefit.
- I certify that the information given by me in applying for payment is correct. I authorize the payment of authorized benefits on my behalf. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

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ADULT HISTORY FORM

Instructions: Please fill out as completely as possible. All information will be kept confidential.
BE SURE TO COMPLETE ALL SIX PAGES OF THIS FORM.

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

MEDICATION ALLERGIES

i.e. Penicillin, Sulfa, Aspirin I.V. Dye, etc.

ALLERGIC TO: _____ REACTION: _____
ALLERGIC TO: _____ REACTION: _____
ALLERGIC TO: _____ REACTION: _____
ALLERGIC TO: _____ REACTION: _____

Latex Allergy: □ Yes □ No

SURGICAL HISTORY

□ Gall Bladder □ Hernia □ Tonsils
□ Appendix □ C-section □ Coronary bypass
□ Uterus (hysterectomy) □ Ovaries removed (one/both)
□ Other (please list): _____

PHYSICIANS (SURGEONS)

_____
_____
_____
_____
_____

MEDICATIONS

Please list all medications that you are now taking; including those that you buy without a doctor's prescriptions such as aspirin, cold tablets, vitamins and herbs. Use a separate sheet if needed.

MEDICATION	DOSE (HOW MUCH)	HOW OFTEN	MEDICATION	DOSE (HOW MUCH)	HOW OFTEN
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day

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SOCIAL/PERSONAL HISTORY

Currently live: □ Alone □ With family □ With friends □ With significant other
Marital status: □ Single □ Married □ Divorced □ Separated □ Widowed
Last grade completed in school: _____ Occupation:_____
Were you sick, but failed to get medical care in the last year? □ Yes □ No
Did you miss more than ten days of your usual activity last year due to illness? □Yes □ No

Do you currently smoke? □ Yes □ No If yes, how much per day? _____How many years? _____
Are you a former smoker? □ Yes □ No Do you chew tobacco? □ Yes □ No
Consume Alcoholic Beverages? □ Yes □ No Number of drinks per week?_____month?_____
Do you use marijuana or other recreational drugs? □ Yes □ No Type:_____

Coffee/Tea? □ Reg. □ Decaf □ None Number of 6oz. cups per day: _____
Pop? □ Reg. □ Decaf □ Diet □ None Number of 12 oz.cups per day: _____

Do you exercise regularly? □ Yes □ No How often? _____ Type of exercise: _____
Do you wear seatbelts? □ Yes □ No
Any guns in the home: □ Yes □ No If yes, are they locked up? □ Yes □ No

Are there any health risks involved in your job, home environments or activities? □ Yes □ No
If yes, explain: _____
_____

SEXUAL HISTORY: □ I would rather discuss this with my caregiver in person.
(The purpose of these questions is to determine your risk factors)
Are you currently sexually active? □ Yes □ No
Do you currently have more than 1 partner? □ Yes □ No Number of previous sex partners? _____
Your sex partners are: □ Male □ Female □ Both
Any history of sexually transmitted disease? □ Yes □ No If yes, what disease? _____
Are you now or have you ever been physically or sexually abused? □ Yes □ No

FEMALES ONLY
Last pap smear date: _____ Last mammogram date:_____
Method of birth control: _____ Last menstrual period date: _____

Age at first period: _____ Age at first intercourse:_____
Periods occur every _____days Flow is □ regular □ irregular Number of days flowing_____

Total number of pregnancies: _____ Age at first pregnancy:_____
Number of miscarriages or abortions: _____ Number of live births:_____
□ Problems during pregnancy _____

□ Lumps in breast □ Discharge from nipple Do monthly breast exam? □ Yes □ No
□ Pain/bleeding with intercourse
□ Currently in Menopause

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CHRONIC MEDICAL PROBLEMS

Please check ALL conditions that apply to you:

☐ High Blood Pressure 401.1
☐ Diabetes well controlled 250.00
☐ Diabetes poorly controlled 250.02
☐ Diabetes with eye or kidney complications 250.91
☐ Coronary Artery Disease 429.2
☐ Metabolic Syndrome / Insulin Resistance 277.7
☐ Elevated Cholesterol 272.4
☐ Elevated Triglycerides ONLY 272.1
☐ Elevated Homocysteine 270.4
☐ Elevated C-Reactive Protein 790.95
☐ Tobacco Use 305.1

☐ Elevated thyroid hormone 242.90
☐ Low thyroid hormone 244.9

☐ Enlarged prostate 600.01
☐ Elevated PSA test 790.3
☐ Low Testosterone 257.2 ☐ Decreased Sex Drive 799.81
☐ Impotence 607.84
☐ Sleep Apnea 780.57

☐ Pre-Menstrual Syndrome (PMS) 625.4
☐ Abnormal PAP smear 795.09
☐ Abnormal Uterine Bleeding 626.8
☐ Fibrocystic Breasts 610.1
☐ Uterine Fibroids 218.9
☐ Frequent Vaginal Infections 616.1
☐ Menopause 627.2 ☐ Decreased Sex Drive 799.81

☐ Glaucoma 365.9
☐ Cataracts 366.9
☐ Hearing Loss 398.9

☐ Chronic Bronchitis 491.9
☐ Emphysema 496
☐ Asthma 493.90
☐ Allergies – seasonal 477.9
☐ Allergies – cats, dogs 477.2

☐ Angina 413.9
☐ Heart Murmur 785.2
☐ Mitral Valve Prolapse 424.0
☐ Aortic Stenosis 424.1

☐ Irritable Bowel Syndrome(IBS) 464.1
☐ Esophageal Reflux 530.81
☐ Diverticulosis 462.11
☐ Stomach Ulcers 531.9
☐ Ulcerative Colitis 556.9
☐ Crohn's Disease 555.9
☐ Gall Bladder Problems 575.1
☐ Hepatitis 571.4

☐ Frequent Urinary Infections 599.0
☐ Kidney Stones 592.0

☐ Migraine Headaches 346.9
☐ Seizure Disorder 780.39
☐ Stroke 436
☐ Alzheimers Dementia 331.0
☐ Multiple Sclerosis 340

☐ Anxiety 300.00
☐ Depression 311
☐ Manic Depression(Bipolar) 296.8
☐ Obsessive Compulsive Disorder(OCD) 300.3
☐ Attention Deficit with hyperactivity(ADHD) 314.01
☐ Attention Deficit without hyperactivity(ADD) 314.00

☐ Acne 706.1 ☐ Psoriasis 696.1
☐ Eczema 691.8
☐ Rosacea 695.3

☐ Arthritis general 716.9
☐ Rheumatoid Arthritis 714.0
☐ Carpal Tunnel Syndrome 354.0
☐ Low Back Pain 724.5
☐ Esophageal Reflux 530.81
☐ Fibromyalgia 729.1

☐ Anemia -iron deficiency 280.9
☐ Anemia – any other type 285.9

CANCER of the:

☐ Breast 174.9
☐ Cervix 180.9
☐ Colon 153.9
☐ Uterus 182.0
☐ Kidney 189.0
☐ Lung162.9
☐ Prostate 185
☐ Skin 173.9
☐ Thyroid 193

Please specify any other chronic medical problems:

_____

_____

_____

_____

_____

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REVIEW OF MEDICAL SYSTEMS

Point Scale	0	*Never* or *almost never* has the symptom	3	*Frequently* have it, effect is *not severe*
	1	*Occasionally* have it, effect is *not severe*	4	*Frequently* have it, effect is *severe*
	2	*Occasionally* have it, effect is *severe*		

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
_____TOTAL

EYES
_____Watery or itchy eyes
_____Swollen, reddened or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
(does not include near- or far-sightedness)
_____TOTAL

EARS
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____TOTAL

NOSE
_____Stuffy nose
_____Sinus Problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
_____TOTAL

MOUTH/ THROAT
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, gums or lips
_____Canker sores
_____TOTAL

SKIN
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating
_____TOTAL

HEART
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain
_____TOTAL

LUNGS
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing
_____TOTAL

DIGESTIVE TRACT
_____Nausea, vomiting
_____Diarrhea
_____Constipation
_____Bloated Feeling
_____Heartburn
_____Intestinal/stomach pain
_____TOTAL

JOINTS/ MUSCLE
_____Pain or aches in joints
_____Arthritis
_____Stiffness or limitation of movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness
_____TOTAL

WEIGHT
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight
_____TOTAL

ENERGY/ ACTIVITY
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
_____TOTAL

MIND
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Difficulty in making decisions
_____Stuttering or stammering
_____Slurred Speech
_____Learning Disabilities
_____TOTAL

EMOTIONS
_____Mood swings
_____Anxiety, fear, nervousness
_____Anger, irritability, aggressiveness
_____Depression
_____TOTAL

OTHER
_____Frequent illness
_____Frequent or urgent urination
_____Genital itch or discharge
_____Sexual Difficulties
_____TOTAL

GRAND TOTAL _____

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FAMILY HISTORY

Grandfather(maternal) □ Living □ Deceased Cause of death_____
Grandmother(maternal) □ Living □ Deceased Cause of death_____
Grandfather(paternal) □ Living □ Deceased Cause of death_____
Grandmother(paternal) □ Living □ Deceased Cause of death_____
Father □ Living □ Deceased Cause of death_____
Mother □ Living □ Deceased Cause of death_____

Siblings # alive_____ # deceased_____ Cause(s) of death _____
Children # alive_____ # deceased_____ Cause(s) of death _____

Spouse/Significant Other's Name _____ Age _____

Children's Names and Ages _____
_____

Diseases in your family. Please check ALL that apply

Allergies or Asthma	**V19.6**	□ Grandparents	□ Parents	□ Siblings	□ Children
Asthma	**V17.5**	□ Grandparents	□ Parents	□ Siblings	□ Children
Alzheimer's or Dementia	**V17.2**	□ Grandparents	□ Parents	□ Siblings	□ Children
Alcoholism	**V61.41**	□ Grandparents	□ Parents	□ Siblings	□ Children
Anemia	**V18.2**	□ Grandparents	□ Parents	□ Siblings	□ Children
Arthritis	**V17.7**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : BLADDER	**V16.52**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : BREAST	**V16.3**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : COLON	**V16.0**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : KIDNEY	**V16.51**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : LUNG	**V16.2**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : OVARY	**V16.41**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : PROSTATE	**V16.42**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : SKIN	**V19.4**	□ Grandparents	□ Parents	□ Siblings	□ Children
Cancer : ANY OTHER	**V16.8**	□ Grandparents	□ Parents	□ Siblings	□ Children
Diabetes	**V18.0**	□ Grandparents	□ Parents	□ Siblings	□ Children
Depression or Anxiety	**V17.0**	□ Grandparents	□ Parents	□ Siblings	□ Children
Epilepsy	**V17.2**	□ Grandparents	□ Parents	□ Siblings	□ Children
Genetic Disease	**V18.9**	□ Grandparents	□ Parents	□ Siblings	□ Children
Heart Trouble	**V17.4**	□ Grandparents	□ Parents	□ Siblings	□ Children
High Cholesterol		□ Grandparents	□ Parents	□ Siblings	□ Children
Kidney or Bladder Disease	**V18.6**	□ Grandparents	□ Parents	□ Siblings	□ Children
Stomach or Duodenal Ulcer	**V18.9**	□ Grandparents	□ Parents	□ Siblings	□ Children
Stroke	**V17.1**	□ Grandparents	□ Parents	□ Siblings	□ Children

Record other family illnesses not listed above:

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What are the main concerns that bring you to our office today?

Patient Signature _____

Date _____/_____/_____

Reviewed by _____**Pazuchowski/Whitmyer/Collinson**