





**Midwest Family Medicine**

12640 E. 12 Mile Road

Warren, MI 48093

(586) 751-2020

**PATIENT HISTORY**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Requesting Physician \_\_\_\_\_

Primary Family Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Occupation \_\_\_\_\_ Retired  Yes  No

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Address \_\_\_\_\_

Are you presently working?  Yes  No

If not, please provide last day you worked full time \_\_\_\_\_

**SPOUSE'S INFORMATION**

Spouse's Name (*if married*) \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Address \_\_\_\_\_



**ALLERGIES** Please list allergies to all medication, foods, dyes or materials.

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**REVIEW OF SYSTEMS** Are you currently experiencing any of the following?

<b>Constitutional</b>	Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>GUI</b>	Urinary Urgency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Sexual Difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Eyes</b>	Blurred Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Muscular/ Skeletal</b>	Joint Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Wear Glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Neck Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>ENT</b>	Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Skin</b>	Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Neck Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Keloids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>CVS</b>	Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Neurological</b>	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Palpitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>GI</b>	Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Fecal Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Where? _____		
					Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
					Where? _____		
<b>Respiratory</b>	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Psychiatric</b>	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Other Psychiatric illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Blood Disorder</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
				(easy bruising, thin blood)			

Are you  Right handed  Left handed

## SOCIAL HISTORY

**Marital Status**     Single     Married     Divorced     Widowed

**Do you have any children?**     Yes     No    If so, how many \_\_\_\_\_

**Do you smoke?**     Yes     No    If so, \_\_\_\_\_ packs per day    how long \_\_\_\_\_

**Do you drink?**     Yes     No    If so, how many drinks per day \_\_\_\_\_

**Do you use drugs?**     Yes     No    If yes, please indicate type and how often \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HEALTH HISTORY

**High Blood Pressure**     Yes     No

**Heart Attack**     Yes     No

**Stroke**     Yes     No

**Cancer**     Yes     No

**Diabetes**     Yes     No

**Seizures**     Yes     No

**Heart Disease**     Yes     No

**Psychiatric/Emotional Problems**     Yes     No

Relationship	IF LIVING		IF DECEASED	
	Age	Health Problems	Age at Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
Aunt / Uncle	_____	_____	_____	_____
Aunt / Uncle	_____	_____	_____	_____
Sister / Brother	_____	_____	_____	_____
Sister / Brother	_____	_____	_____	_____
Children	_____	_____	_____	_____

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_



## St. John Health Notice of Privacy Practices

### 1. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### 2. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information “protected health information” or “PHI” for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Health facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at [www.stjohn.org](http://www.stjohn.org).

### 3. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

#### 3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

We may use and disclose your PHI for the following reasons:

- 3.1.1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you’re being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.
- 3.1.2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.
- 3.1.3. **For health care operations.** We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and others in order to make sure we are complying with the laws that affect us.

#### 3.2. Certain Other Uses and Disclosures That Do Not Require Your Consent

- 3.2.1. **When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.
- 3.2.2. **For public health activities.** For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual’s death.
- 3.2.3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- 3.2.4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
- 3.2.5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct research.
- 3.2.6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- 3.2.7. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- 3.2.8. **For workers’ compensation purposes.** We may provide PHI in order to comply with workers’ compensation laws.
- 3.2.9. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.
- 3.2.10. **Fundraising activities.** We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

#### 3.3. Uses and Disclosures to Which You Have an Opportunity to Object

- 3.3.1. **Patient directories.** We may include your name, location in this facility, general condition and religious affiliation (if any) in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part.
- 3.3.2. **Disclosure to family, friends, or others.** We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.
  - 3.3.2.1. Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

#### 3.4. All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

#### 4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

**4.1. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**4.2. The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

**4.3. The Right to See and Get Copies of Your PHI.** In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you a reasonable copying fee.

**4.4. The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures listed in section 3.1, 3.2 and 3.3. The list also will not include any uses or disclosures made before April 14, 2003.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you \$25 for each additional request.

**4.5. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

**4.6. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

#### 5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **St. John Health HIPAA Privacy Office** - (See section 7 of this Notice.)

You also may send a written complaint to:

Secretary of the Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

We will take no retaliatory action against you if you file a complaint about our privacy practices.

#### 6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments and units of the following entities:

Brighton Hospital	St. John Hospice
Providence Hospital and Medical Centers	St. John Home Infusion
St. John Detroit Riverview Hospital	St. John Home Medical Equipment
St. John Hospital and Medical Center	Medical Resources Group
St. John Macomb Hospital	Michigan Mobile Lithotripsy
St. John NorthEast Community Hospital	Eastwood Clinics
St. John North Shores Hospital	St. John Health Foundation
St. John Oakland Hospital	St. John Health Occupational Health Partners
St. John River District Hospital	Affiliated Health Services, Inc.
Father Murray Nursing Center	Community Health Investment Corp.
St. John Senior Community	St. John Health
St. John Home Care	

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for purposes of treatment, payment, or hospital operations as described in this notice.

#### 7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the St. John Health Corporate HIPAA Privacy Officer at 586-753-0664. All complaints must be submitted in writing to:

St. John Health  
HIPAA Privacy Officer  
28000 Dequindre Road  
Warren, MI 48092

#### 8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003.

**MIDWEST FAMILY MEDICINE**  
**SAM AWADA, M.D.**  
12640 E. 12 MILE ROAD  
WARREN, MI 48093  
(586) 751-2020  
(586) 751-7872 – FAX

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ A COPY OF  
MIDWEST FAMILY MEDICINE NOTICE OF PRIVACY PRACTICES  
LITERATURE.

\_\_\_\_\_  
NAME (PLEASE PRINT)

\_\_\_\_\_  
SIGNATURE DATE: \_\_\_\_\_

\_\_\_\_\_  
WITNESS DATE: \_\_\_\_\_

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT:  
.....

ON \_\_\_\_\_, \_\_\_\_\_ PRESENTED THIS  
ACKNOWLEDGMENT TO \_\_\_\_\_. THE PATIENT HAS  
REFUSED TO PROVIDE THE SIGNATURE REQUESTED:

.....

DOCUMENTATION OF PATIENT RECEIPT OF A COPY OF PRIVACY  
PRACTICES OF MIDWEST FAMILY MEDICINE:

ON \_\_\_\_\_, \_\_\_\_\_ RECEIVED A COPY OF  
THE PRIVACY PRACTICES OF MIDWEST FAMILY MEDICINE BY, \_\_\_\_\_,  
A STAFF MEMBER OF MIDWEST FAMILY MEDICINE.

**MIDWEST FAMILY MEDICINE**  
**SAM AWADA, M.D.**  
12640 E. 12 MILE ROAD  
WARREN, MI 48093  
(586) 751-2020  
(586) 751-7872 - FAX

**RECORD RELEASE AUTHORIZATION**

TO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY RECORDS AS INDICATED BELOW:

**SAM AWADA, M.D.**

THE COMPLETE HISTORY OF RECORDS, INCLUDING, BUT NOT LIMITED TO X-RAYS, PROGRESS NOTES, LABS, AND EKGS FOR THE FOLLOWING PERIOD:

START DATE: \_\_\_\_\_ THROUGH \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARDIAN/PARENT IF UNDER 18: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

THE ABOVE INFORMATION IS TO BE USED IN COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996.