Mothers and Daughters Women's Center

PATIENT QUESTIONNAIRE – MEDICAL/SURGICAL HISTORY

NAME:	AGE:
REFERRED BY:	

1. What is the main problem you are having which brought you to this office today?

_____

_____

2. Do you currently have or have you had any of the following medical problems?

Diabetes.....	YES ☐ NO ☐	High Blood Pressure.....	YES ☐ NO ☐
Epilepsy.....	YES ☐ NO ☐	Blood Disease.....	YES ☐ NO ☐
Migraine Headaches.....	YES ☐ NO ☐	Gonorrhea, Syphilis, PID.....	YES ☐ NO ☐
Tuberculosis.....	YES ☐ NO ☐	Thrombophlebitis.....	YES ☐ NO ☐
Rheumatic Fever.....	YES ☐ NO ☐	Hay Fever or Asthma.....	YES ☐ NO ☐
Cancer.....	YES ☐ NO ☐	Gastro-Intestinal Disease.....	YES ☐ NO ☐
Heart Disease.....	YES ☐ NO ☐	Liver Disease.....	YES ☐ NO ☐
Lung Disease.....	YES ☐ NO ☐	Any Others Not Mentioned: _____	

_____

3. Have you, your family, your husband or your husband's family ever had any:

Metabolic Disorders (i.e., disease where chemicals are missing from the body)..... YES ☐ NO ☐
Chromosomal Disorders (i.e., Down's Syndrome or Mongolism)?..... YES ☐ NO ☐
Genetic Defects (i.e., Spina Bifida, Anencephaly or Meningomyelocele)?..... YES ☐ NO ☐
Defects in the Nervous System?..... YES ☐ NO ☐

4. Does anyone in your immediate family currently have or have they had any of the medical problems listed below?

Cancer.....	YES ☐ NO ☐	Tuberculosis.....	YES ☐ NO ☐
Diabetes.....	YES ☐ NO ☐	Heart Trouble.....	YES ☐ NO ☐
Stroke.....	YES ☐ NO ☐	High Blood Pressure.....	YES ☐ NO ☐
Epilepsy.....	YES ☐ NO ☐	High Cholesterol.....	YES ☐ NO ☐

5. Have you had any surgical procedures for the following?

Tonsils.....	YES ☐ NO ☐	Stomach.....	YES ☐ NO ☐
Appendix.....	YES ☐ NO ☐	Gall Bladder.....	YES ☐ NO ☐
Hernia.....	YES ☐ NO ☐	Varicose Veins.....	YES ☐ NO ☐
Hemorrhoids.....	YES ☐ NO ☐	Thyroid.....	YES ☐ NO ☐
Hysterectomy.....	YES ☐ NO ☐	Cesarean Section.....	YES ☐ NO ☐
Ovaries.....	YES ☐ NO ☐	Tubes.....	YES ☐ NO ☐
Breasts.....	YES ☐ NO ☐	Any Others Not Mentioned: _____	

_____

6. Have you ever had blood transfusions or plasma? ...YES ☐ NO ☐

7. Are you currently on any medications?.....YES ☐ NO ☐ If yes, what medications? _____

_____

8. Are you allergic to anything?..... YES ☐ NO ☐ If yes, what are you allergic to? _____

9. Do you smoke?..... YES ☐ NO ☐ If yes, how much? _____

10. Do you drink alcohol?..... YES ☐ NO ☐ If yes, how much? _____

11. Do you drink coffee?..... YES ☐ NO ☐ If yes, how much? _____

Mothers and Daughters Women's Center

PATIENT QUESTIONNAIRE – MEDICAL/SURGICAL HISTORY (page 2)

12. How old were you when your periods started? _____

Are your periods regular? _____

What is the length of time between the first day of one period and the first day of the next period? _____

How many days does your period last? _____

How heavy is your menstrual flow? Light _____ Moderate _____ Heavy _____

When was your last normal menstrual period? _____

Do you have pain with intercourse? _____

Do you bleed with intercourse? _____

13. Do you take birth control pills? YES ☐ NO ☐

If yes, number of years _____. If No, what type of contraceptive(s) do you use? _____

14. If age 35 or over, have you had a baseline screening mammogram? YES ☐ NO ☐

If over 40, are you having a mammogram every other year? YES ☐ NO ☐

If over age 50, are you having yearly mammograms? YES ☐ NO ☐

15. How many times have you been pregnant? _____

How many children born alive? _____ How many stillbirths? _____

How many premature? _____ How many caesareans? _____

How many miscarriages? _____ How many abortions? _____

Have you had any complications with pregnancy? _____

_____

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.

The preceding information is correct and current.

_____ _____

PATIENT SIGNATURE DATE

Rebecca Metz, M.D.

PATIENT'S NAME			DATE
STREET ADDRESS			HOME PHONE
CITY	STATE	ZIP	CELL PHONE
MARITAL STATUS	DATE OF BIRTH	AGE	PERSONAL EMAIL
EMPLOYED BY			OCCUPATION
BUSINESS ADDRESS			BUSINESS PHONE
CITY	STATE	ZIP	

SPOUSE'S NAME			DATE OF BIRTH
EMPLOYED BY			OCCUPATION
BUSINESS ADDRESS			BUSINESS PHONE
CITY	STATE	ZIP	

In order to submit a claim for payment for office or hospital services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize Rebecca Metz, M.D. to furnish any information to insurance carriers concerning my illness and treatment which is deemed necessary to process insurance claims. I hereby assign to the physician all payments for medical services rendered to myself. I understand I am financially responsible to Rebecca Metz, M.D. for any balance not covered by this authorization.

_____ _____

SIGNATURE DATE

Payment is due at time of all office visits, regardless of insurance coverage.

HOW DID YOU HEAR OF OUR PRACTICE?

Mothers and Daughters
Women's Center

854 Mountain Avenue, Mountainside, NJ 07092
Tel 908-317-9922 Fax 908-317-9544

Patient Consent Form

Regarding the Use & Disclosure of Health Information

I understand that some of my health information may be used and /or disclosed by the office of Dr. Rebecca Metz to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I should refer to your privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time your privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of the notice as revised, I can call your office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Signature: _____ Date: _____

Mothers and Daughters
Women's Center

854 MOUNTAIN AVENUE, MOUNTAINSIDE NJ 07092
PHONE: 908-317-9922 FAX: 908-317-9544

The Health Insurance Portability and Accountability Act of 1996, HIPAA, requires that our office has your consent prior to our healthcare professional discussing your personal health with your family member, friend, or other caregiver. **I understand that I am not required to list anyone.** I also understand that I may change this list at any time in writing.

Can we leave a voice message for you:

Home No. _____ Yes _____ No _____

Cell No. _____ Yes _____ No _____

Work No. _____ Yes _____ No _____

Can we release information to a family member? If so, to whom:

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

This authorization will be in effect until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization.

You do not have to complete this authorization to receive treatment from the physicians in this practice.

Personal health information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your health care condition.

_____ _____

Signature Date:

Mothers and Daughters
Women's Center
854 Mountain Avenue, Mountainside, NJ 07092
Tel 908-317-9922 Fax 908-317-9544

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, am aware of what HIPAA means. If I am not aware, copies will be given of Mothers and Daughters Women's Center Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____ _____
Witness Date