KATHERINE L. BOYD
M.D., P.C., F.A.C.O.G.

38600 Van Dyke Avenue Suite130, Sterling Heights, MI 48312
Phone: 586-573-7222 **FAX:** 573-573-7267 kathboyd.com

Dear Patient, Welcome to our Practice!

Your exam must be scheduled 365 days from your prior exam. (Unless your insurance has changed) Please let us know.

This exam includes but is not limited to a:

1) Screening Pap Smear
2) Gonorrhea and Chlamydia Culture
3) Stool Hemoccult (if appropriate)
4) Wet Mount (if indicated)
5) Clinical Breast Exam
6) Blood Work, Mammograms and Ultrasound Prescriptions (as needed).
7) Prescriptions for needed medications
8) Physical Exam

It is important that you **check/call** your insurance carrier for coverage and payment policies.

When inquiring with your insurance carrier, ask the following questions:

"Does my contract include payment for a Well Women office visit?"

"Does my contract include payment or a yearly screening Pap smear?"

"Does my contract include payment for Gonorrhea and Chlamydia cultures?"

"Does my contract include payment for bacterial cultures?"

It is important to note:

- Not all insurances cover screening exams and testing.
- **When/if the claim is rejected, the patient is responsible for the fee.**
- At the time of your appointment please inform us of any procedure you do not wish to have done.

I request that_____ not be performed.

Signature_____ Date _____

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Dr. Boyd would like to thank you for taking the time to complete this short questionnaire. We apologize for any inconvenience. Electronic Health Records serve as an important facilitator for collecting patient demographic data. The 2009 economic stimulus bill and 2010 health system reform bills, both strongly encourage collection of this data. Due to recent government initiatives to promote the use of electronic health records and in compliance with Meaningful Use, the reporting of the patient's racial background is now a requirement. Please complete the following information regarding the patient who is being seen today.

If you are uncomfortable answering the questions, you may select "I refuse to report".

Patient Name:_____

Date:_____

eMail:_____

Pharmacy Name/Address Phone:_____

This office may ePrescribe and view my external history prescriptions: Yes or No (answer required)

How would you describe the patient's race? (Please mark an "X" in the box adjacent to the answer that best describes this.)

Place Of Birth: _____

Race:

___American Indian or Alaska Native

___Asian

___Native Hawaiian or Other Pacific Islander

___Black or African American

___White

___Hispanic

___Other Race:_____

___Unreported/Refused to Report

Ethnicity:

___Hispanic or Latino

___Not Hispanic or Latino

___Refused to Report

Language:

___English

___Indian (includes Hindi & Tamil)

___Spanish

___Russian

___Other:_____

Please also list your Primary Care Physician:_____

Patient/Guardian Signature:_____Date:_____

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PATIENT REGISTRATION

PATIENT NAME _____

BIRTHDAY _____ AGE_____ MARITAL STATUS S M D W

SOCIAL SECURITY #_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

HOME PHONE # _____ CELL PHONE #_____

EMPLOYER_____ WORK # _____

MAY WE CONTACT YOU AT WORK? YES NO

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ PHONE # _____

REFERRED BY_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

SUBSCRIBER _____ DOB_____

ADDRESS IF DIFFERENT THAN ABOVE _____

ID # _____ EMPLOYER _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

SECONDARY INSURANCE _____

SUBSCRIBER _____ DOB _____

ADDRESS IF DIFFERENT THAN ABOVE _____

ID # _____ EMPLOYER _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

EMERGENCY CONTACT

NAME: _____ RELATION: _____

PHONE # _____ WORK # _____

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MEDICAL HISTORY REVIEW

Since your last visit have you had any of the following?

___Weight Loss ___Abnormal Bleeding ___Breast Pain

___Weight Gain ___Pelvic Pain ___Nipple Discharge

___Vision Changes ___Muscle Weakness ___Seizures

___Headaches ___Urinary Incontinence ___Hot Flashes

___Sinus Problems ___Urinary Frequency ___Night Sweats

___Chest Pain ___Diarrhea ___Cough

___Edema ___Abdominal Pain ___Wheezing

___Allergic Reaction ___Hospitalizations ___Major Illness

___Surgery ___Injuries ___Physical Abuse

___Living Will ___Depression

Has anyone in your family been diagnosed with the following?

___Diabetes ___Cancer ___Heart Disease

___High Cholesterol ___Hypertension

Do You?

___Smoke ___Use Alcohol ___Use Street Drugs

___Use Seat Belts ___Exercise Regularly ___ Wear a Bike Helmet

Do you have any problems or concerns? _____

_____

Is this a new or old problem? _____

When did it start?_____

Describe your signs and symptoms_____

Have you tried anything to fix the problem?_____

Your exam ***may*** include, but is ***not limited to*** physical exam, pap smear, gonorrhea, chlamydia and trichomonas culture, bacterial culture, candida culture, stool hemoccult, wet mount and breast exam. Not all insurances cover screening exams and testing. If the claim is rejected, you will be responsible for the fee. You must inform us below if you do not want a procedure done.

*I request that*_____*not be performed.*

Signature_____ Date_____

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ____/____/____ PATIENT # _____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
Place of birth _____
Highest level in school _____
Occupation _____
Previous occupations _____
Marital status _____
Hobbies _____
Exercise/recreation _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam _____
Please list all allergies (foods, drugs, environment)

When was your last physical exam? _____
Name of doctor _____ Phone _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ none

Please list all medicines you are currently taking (include nonprescription drugs): ☐ none

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ none

Chief Complaints
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV+	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Mitral Valve Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma transfusions	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes				Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood pressure	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes				Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	(please list) _____		
Bladder Infections	no	yes	Date of last chest x-ray _____					
Epilepsy	no	yes	Asthma	no	yes			

Family History
Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	no	yes		Stroke	no	yes	
Tuberculosis	no	yes		Epilepsy	no	yes	
Diabetes	no	yes		Allergies	no	yes	
Heart Disease	no	yes		Anemia	no	yes	
High blood pressure	no	yes		Bleeding tendency	no	yes	

Family History (cont.)
(Circle "no" or "yes", leave blank if uncertain)

			Relationship		Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Asthma	no	yes		Father		
Chronic lung disease	no	yes		Mother		
Drug or alcohol problem	no	yes		Siblings		
Mental Illness	no	yes				
Leukemia	no	yes				
Migraine headaches	no	yes				
Obesity	no	yes				
Thyroid Disease	no	yes		Spouse		
Ulcer	no	yes		Children		
Depression	no	yes				
High Cholesterol	no	yes				
Kidney Disease	no	yes				
Glaucoma	no	yes				
Gout	no	yes				

Do you have now or have you had within the past year:
(Circle "no" or "yes", leave blank if uncertain)

~~Weakness or paralysis~~	~~no~~	~~yes~~	~~Bloody sputum~~	~~no~~	~~yes~~	~~Joint pain or stiffness~~	~~no~~	~~yes~~
Tire easily or weakness	no	yes	Wheezing	no	yes	Swollen joints	no	yes
Recent weight changes	no	yes	Chest pain or discomfort	no	yes	Muscle cramps or spasms	no	yes
Change in appetite	no	yes	Purple fingers or lips	no	yes	Sleeplessness	no	yes
Sensitivity to cold or heat	no	yes	Swelling of hands, feet or ankles	no	yes	Seizures	no	yes
Persistent fever	no	yes	Difficulty in breathing	no	yes	Depression	no	yes
Night sweats or hot flashes	no	yes	Palpitations or fluttering of the heart	no	yes	Memory loss	no	yes
Skin rash	no	yes	Leg cramps on walking or at night	no	yes	Poor coordination	no	yes
Skin trouble or changes	no	yes	Enlarged veins	no	yes	Dizziness or fainting spells	no	yes
Change in nails or hair	no	yes	Difficulty swallowing	no	yes	A living will or advance directive	no	yes
Headaches	no	yes	Heartburn	no	yes	**Men only:**		
Easy bleeding or bruising	no	yes	Frequent belching	no	yes	Discharge from penis	no	yes
Double vision	no	yes	Abdominal cramping	no	yes	Pain or lump in testicles	no	yes
Blurred vision	no	yes	Nausea	no	yes	Impotence	no	yes
Eye pain	no	yes	Vomiting	no	yes	**Women only:**		
Infected eyes	no	yes	Vomited or coughed up blood	no	yes	Age period began _____		
Do you wear glasses or contacts	no	yes	Chronic diarrhea	no	yes	How many days do periods last? _____		
When was your last eye exam_____			Chronic constipation	no	yes	How many days between periods? _____		
Ringing in the ears	no	yes	Rectal bleeding	no	yes	Is the flow heavy?	no	yes
Discharge from ears	no	yes	Black tarry stools	no	yes	Do you bleed or spot between periods?	no	yes
Ear pain	no	yes	Dark urine	no	yes			
Decrease in hearing	no	yes	Yellow jaundice	no	yes	Do you have pain or cramps?	no	yes
Frequent nosebleeds	no	yes	Frequent urination (day)	no	yes	Date of last period? _____		
Frequent colds	no	yes	Frequent urination (night)	no	yes	Date of last pelvic exam? _____		
Sinus trouble	no	yes	Increase in thirst	no	yes	Date of last mammogram? _____		
Loss of smell	no	yes	Painful urination	no	yes	Any itching in vaginal area?	no	yes
Persistent hoarseness	no	yes	Leakage of urine	no	yes	Pain with intercourse?	no	yes
Sore throat	no	yes	Difficulty in starting urine	no	yes	Type of birth control used? _____		
Sore tongue or gums	no	yes	Blood in urine	no	yes	Number of pregnancies _____		
Lump or discharge from breast	no	yes	Lack of sex drive	no	yes	Number of full term births _____		
Chronic or frequent cough	no	yes	Hemorrhoids	no	yes	Number of preterm births _____		
Shortness of breath	no	yes	Backaches	no	yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X _____ _____
Signature of patient or parent if minor — Date

Physician's Comment

Physician's Signature _____