



Pfenninger
**MEDICAL
PROCEDURES
CENTER P.C.**

It is very important to provide accurate past and current health information for your proper care. Please let us know if this information changes in any given way at any time. Incorrect information can be dangerous to your health.



"We treat people, not just problems"...since 1989.

4800 N. Saginaw Rd., Midland, MI 48640 (989) 631-4545 Fax (989) 631-9949

Visit our website at: MPCenter.net

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The Medical Procedures Centers, P.C.

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Jan Driik, MD, PLLC and
 Medical Procedures Center, PC
 are separate entities.

MEDICAL HISTORY

It is very important to provide accurate past and current health information for your proper care. Please let us know if this information changes in any given way at any time. Incorrect information can be dangerous to your health.

Name: _____ Date of Birth: _____ Age: _____
 Address: _____ Name of personal physician: _____
 _____ Name of referring physician: _____
 Employer: _____ How did you find out about our office and practice?
 Occupation: _____
 Marital Status: **M D S W** No. of Children: _____ Have you visited our website? **Y N**
 If married, name of spouse: _____ Occupation: _____

Do you want a copy of your records sent to your personal physician? **Yes No** A copy will be sent to the doctor who referred you also.

If yes, which Name: _____
 physician(s) Address: _____

Describe your overall health condition: **Good Fair Poor**

Are you or is there a chance you are pregnant? **Yes No NA**

Check (✓) the appropriate space for any condition you have:

	Now	Past	No		Now	Past	No		Now	Past	No
Eczema				Fainting History				Frequent Headaches			
Artificial Heart Valve				Glaucoma				Chest Pain			
Heart Murmur				Nervous Problems				Frequent Cough			
Heart Surgery				Psychiatric Care				Shortness of Breath			
Rheumatic Fever				Sickle Cell Disease				Ankle Swelling			
Pacemaker				Colon Polyps				Slow Healing			
Heart Disease				Stomach Reflux (GERD)				Rectal Bleeding			
High Blood Pressure				Ulcer				Hemorrhoid Problems			
Circulatory Problem				Malignancies/Cancers				Weight Loss			
Stroke				type _____				Fevers, Sweats			
Bleeding Tendencies				when _____				Change in mole or skin growth			
Blood Clots				Radiation/Chemotherapy				Genital Warts			
Hay Fever/Allergies				Anemia/Leukemia				Breast Lump			
Asthma				Seizures				Abnormal Pap Smear			
Emphysema				Tuberculosis (TB)				Unusual Uterine Bleeding			
High Cholesterol				Exposure to AIDS							
Diabetes				Venereal Disease							
Arthritis				Blood Transfusions							
Osteoporosis/penia				Drug Abuse							
Gout				Alcohol Abuse							
Joint Replacements				Smoker? Amount _____							
Hypoglycemia				Quit? When? _____							
Thyroid Disorders				Other Problems?							
Kidney Disorders				Please List: _____							
Enlarged Prostate											
Hepatitis or Jaundice											

List **allergies** to medications:
 None or: _____

Do you take Blood Thinners? **Y N**
Have a Pacemaker? **Y N**

List past hospitalizations or surgeries: _____

For Women - Number of pregnancies: _____ Deliveries: _____ Miscarriages or abortions: _____ Birth Control Method: _____

List all medications you are taking: _____

Have you been told you need antibiotics before surgery or teeth cleaning? **YES NO**

Do you take: Aspirin? **Y N** Vitamins? **Y N** Fish or Flaxseed Oil? **Y N** Calcium? **Y N**

PREVENTIVE HEALTH

	Year	Result
Last Cholesterol		
Last Bone Density Test		(men and women over 65)
Last Pap Smear		(women)
Last Mammogram		(women over 40)
Last PSA (men, prostate)		(men over 50)
Last test for blood in stool		(men and women over 50)
Last Sigmoidoscopy/Colonoscopy		(men and women over 50)
Last Cardiac Stress Test		

If you are a male smoker, over 65 y.o., did you have an abdominal ultrasound checking for aortic aneurysm? **Y N**

Last Physical _____
 Last Tetanus (every 10 years) _____
 (Last Flu Shot (every year) _____)
 Last Pneumonia Shot (once age 65) _____
 Herpes Zoster/Shingles vaccine _____
 HPV (Gardasil) vaccine _____
 Do you want us to update your immunizations? **Y N**

How well do you tolerate pain? Well OK Poorly

Do you have a tendency to faint? Y N

FAMILY HISTORY

Please list **medical conditions** (we **DO NOT** need names) that you know of in your family members listed below. Be as specific as you can, **ESPECIALLY REGARDING CANCER**. List cause of death (if applicable) and age at diagnosis if known.

Father's Side

Grandfather:

Grandmother:

Father:

Uncles:

Aunts:

Cousins:

Mother's Side

Grandfather:

Grandmother:

Mother:

Uncles:

Aunts:

Cousins:

PHYSICIAN COMMENTS

	How Many Alive?	How Many Deceased?	List Their Health Problems:
Brothers			
Sisters			
Sons			
Daughters			

Did you read the information provided about the procedure we're going to do today? _____

Would you like any patient education information about the procedures/surgeries we do here? _____

Any questions? _____

I grant the right to release health information obtained from me, and information about my medical treatment to third party payors, and/or other health practitioners as noted.

Signature: _____ Date: _____

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

The undersigned patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the Medical Procedures Center, P.C.'s "Notice of Privacy Policies" on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Medical History Update

Date: _____

No Changes

If changes, please list:

Health changes: _____

Surgeries: _____

Medications: _____

Other: _____

Patient Signature _____

Date: _____

No Changes

If changes, please list:

Health changes: _____

Surgeries: _____

Medications: _____

Other: _____

Patient Signature _____

Date: _____

No Changes

If changes, please list:

Health changes: _____

Surgeries: _____

Medications: _____

Other: _____

Patient Signature _____

Mission Statement:

The Medical Procedures Center, P.C. specializes in office surgery and procedural medicine. It is our goal to treat patients, not just problems. We do not replace the need for a family doctor or other primary care physicians; rather, our purpose is to assist our patients along with their doctors to improve their personal well-being.

Our mission is to provide, reliable, high quality, state-of-the-art screening, diagnosis and treatment for those needing any of a variety of outpatient procedures. We strive to limit health care costs, while including patients as an integral part of the health care decision process.

Our intent is not only to prevent disease and diagnose conditions at an early stage, but to provide procedures that improve the quality of life for our patients.