



*Roufaida N. Al-Misky, MD, FAAFP*

Please answer all questions to ensure the highest quality of care. If something does not apply to you, please leave blank.

**NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ **AGE** \_\_\_\_\_

Do you currently have or have you had any of the following? Check all that apply. Please specify (if applicable) below in the provided spaces.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Depression             | <input type="checkbox"/> High Cholesterol                 | <input type="checkbox"/> SARS-CoV-2/COVID 19 |
| <input type="checkbox"/> Angina                     | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> HIV                              | <input type="checkbox"/> Seizures/Epilepsy   |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Ear Problems           | <input type="checkbox"/> Kidney Disease/stones            | <input type="checkbox"/> Shingles/Zoster     |
| <input type="checkbox"/> Arthritis Type _____       | <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Liver Disease                    | <input type="checkbox"/> Skin Problems       |
| <input type="checkbox"/> Artificial Joints          | <input type="checkbox"/> Emphysema/COPD         | <input type="checkbox"/> Lung Disease                     | <input type="checkbox"/> STI/STD Type _____  |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Eye Disorder           | <input type="checkbox"/> Lupus                            | <input type="checkbox"/> Stomach Disease     |
| <input type="checkbox"/> Autoimmune Disease         | <input type="checkbox"/> Fractures/Broken Bones | <input type="checkbox"/> Nerve Damage                     | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Back Problems/Injury       | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Neurological Disease             | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Bladder Problems           | <input type="checkbox"/> Hay Fever/Allergies    | <input type="checkbox"/> Osteoporosis                     | <input type="checkbox"/> Trauma              |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Head Injury            | <input type="checkbox"/> Phlebitis/Vein Problems          | <input type="checkbox"/> Ulcers of Stomach   |
| <input type="checkbox"/> Cancer Type _____          | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Pneumonia                        | <input type="checkbox"/> Violence            |
| <input type="checkbox"/> Cardiac Defibrillator      | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Prostate Problems                | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Cardiac Pacemaker          | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Prediabetes                      | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Chronic Bronchitis         | <input type="checkbox"/> Hepatitis Type _____   | <input type="checkbox"/> Psychiatric/Mental Health Issues |  |
| <input type="checkbox"/> Colon Disease              | <input type="checkbox"/> Hiatal Hernia          | <input type="checkbox"/> Radiation Therapy                |  |
| <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Recent Weight Loss               |  |

<b>MAJOR HOSPITALIZATIONS</b>	<b>DIAGNOSIS</b>	<b>DATE</b>
1. _____	_____	_____
2. _____	_____	_____

<b>OPERATIONS OR PROCEDURES</b>	<b>DIAGNOSIS</b>	<b>DATE</b>
1. _____	_____	_____
2. _____	_____	_____

<b>LIST ANY KNOWN ALLERGIES TO MEDICATIONS, FOODS, ENVIRONMENTAL/LATEX</b>	<b>REACTION?</b>
1. _____	_____
2. _____	_____

<b>LIST PHYSICIANS WHO CURRENTLY TREAT YOU</b>	<b>SPECIALTY</b>	<b>DIAGNOSIS</b>
1. _____	_____	_____
2. _____	_____	_____

**Disease**                      **Relationship(s)** (please specify maternal (mother’s side) or paternal (father’s side) if applicable)

Heart Disease               Mother         Father  
     Sibling (Male/Female)         Other(s)

Diabetes                       Mother         Father  
     Sibling (Male/Female)         Other(s)

Stroke                       Mother         Father  
     Sibling (Male/Female)         Other (s)

High Cholesterol               Mother         Father  
     Sibling (Male/Female)         Other(s)

Hypertension               Mother         Father  
     Sibling (Male/Female)         Other(s)

Kidney Disease               Mother         Father  
     Sibling (Male/Female)         Other(s)

Bleeding Disorders               Mother         Father  
     Sibling (Male/Female)         Other(s)

Genetic Disorders               Mother         Father  
     Sibling (Male/Female)         Other(s)

Mental Health (i.e. Depression) **(PLEASE SPECIFY TYPE OF ILLNESS/PROBLEM)**

Mother         Father  
 Sibling (Male/Female)         Other(s)

GI Disease                       Mother         Father  
     Sibling (Male/Female)         Other(s)

Cancers **(PLEASE SPECIFY TYPE)**

Mother         Father  
 Sibling (Male/Female)         Other(s)

**Family Medicine and Wellness, PLLC Roufaida N. Al-Misky, MD, FAAFP**

1579 W Big Beaver RD, STE B5, Troy, MI 48084-3504

Phone 248.759.0993 info@dralmisky.com

**PATIENT MEDICATION/VACCINATION/SOCIAL HISTORY**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICATION LIST**

*Please include prescriptions, patches, inhalers, drops, medication implants or pumps, over the counter medications vitamins/supplements, & herbal products.*

Medication	Dose	Instructions for use
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

**SOCIAL HISTORY**

**Smoking:**

**Tobacco:** Never \_\_\_ Occasional(monthly) \_\_\_ Frequently(weekly) \_\_\_ Daily \_\_\_\_\_  
Did you smoke tobacco in the past? \_\_\_\_\_ How many years? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Vaping:** Never \_\_\_ Occasional(monthly) \_\_\_ Frequently(weekly) \_\_\_ Daily \_\_\_\_\_  
Did you vape in the past? \_\_\_\_\_ How many years? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Alcohol Consumption:** Never \_\_\_ Occasional(monthly) \_\_\_ Frequently(weekly) \_\_\_ Daily \_\_\_\_\_

**Recreation Drugs?** YES / NO What kind? \_\_\_\_\_

**Sexually Active?** YES / NO How many lifetime partners? \_\_\_\_\_ Female Partners / Male Partners / Both (circle)

**VACCINATIONS**

Are you up to date on immunizations? YES / NO

*Please circle if you have had the following vaccines:*

*Are you interested in receiving?*

YES / NO TDAP (Tetanus, Diphtheria, Pertussis)

INTERESTED / NOT INTERESTED

YES / NO FLU (Influenza)

INTERESTED / NOT INTERESTED

YES / NO PCV13, PCV15, PCV20, PPSV23 (Pneumococcal)

INTERESTED / NOT INTERESTED

YES / NO HEP B (HEPATITIS B)

INTERESTED / NOT INTERESTED

YES / NO HPV (Human Papillomavirus)

INTERESTED / NOT INTERESTED

YES / NO RZV (Shingles)

INTERESTED / NOT INTERESTED

YES / NO RSV (Respiratory Syncytial Virus)

INTERESTED / NOT INTERESTED

YES / NO COVID-19 (Coronavirus disease 2019)

INTERESTED / NOT INTERESTED

FEMALE PATIENTS

Age at first period: \_\_\_\_\_

Is your period regular? \_\_\_\_\_

Any problem with your period?  Yes  No
 Heavy flow  Clots  Pain/Cramping
 Irregular periods  Discharge  spotting
 Bleeding between periods
OTHER \_\_\_\_\_

First day of last period: \_\_\_\_\_

Duration of period: \_\_\_\_\_

Frequency of cycle (days): \_\_\_\_\_

If Menopausal History:

Age/year began \_\_\_\_\_

Any postmenopausal bleeding?  Yes  No

Contraceptive History:

Are you currently sexually active?  Yes  No
How many lifetime partners? \_\_\_\_\_
How many in the last year? \_\_\_\_\_
Do you use any birth control methods?  Yes  No
 Abstinence  Condoms  Oral Contraceptive
 Depo-Provera  Patch  Vaginal Ring
 Tubal ligation  Implant  Partner Vasectomy
 Diaphragm  Rhythm  Spermicides
 IUD Date of Insertion/type? \_\_\_\_\_

Preventive Care History:

Last Pap Smear Date: \_\_\_\_\_  Normal  Abnormal
Last Mammogram Date: \_\_\_\_\_  Normal  Abnormal
Last Colonoscopy Date: \_\_\_\_\_  Normal  Abnormal

Other:

\_\_\_\_\_  
\_\_\_\_\_

Gynecological History:

Have you had any of the following?

- Abnormal Pap Smear  Breast Pain  Chronic Pelvic Pain
 DES Exposure  Endometriosis  Genital Warts
 PID  PMS  UTI
 Infertility  Polycystic Ovary Disease
 Fibroids  Pain with Intercourse
 Recurrent Miscarriage  Urinary Incontinence
 STD \_\_\_\_\_ OTHER: \_\_\_\_\_

Pregnancy History:

Are you currently pregnant?  Yes  No
Are you planning to get pregnant?  Yes  No
Total number of pregnancies \_\_\_\_\_
Number of full-term delivery \_\_\_\_\_
Number of premature delivery \_\_\_\_\_
Number of vaginal birth \_\_\_\_\_
Number of C-Sections \_\_\_\_\_
Number of Abortion \_\_\_\_\_  Induced  Spontaneous
Number of ectopic \_\_\_\_\_
Multiple Births \_\_\_\_\_
Number of living Children \_\_\_\_\_

Family History:

Table with 2 columns: Disease and Relationship(s). Rows include Breast Cancer, Ovarian Cancer, Uterine Cancer, and Cervical Cancer with checkboxes for Mother, Sibling, and Other(s).

Other:

\_\_\_\_\_  
\_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES PRIVACY REGULATION CONSENT

**Family Medicine and Wellness, PLLC**

1579 W Big Beaver RD, STE B 05, Troy, MI 48084-3504 info@dralmisky.com Phone 248.759.0993 Fax 833.955.3554

Roufaida N. Al-Misky, MD, FAAFP

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**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.**

The **Health Insurance Portability and Accountability Act of 1996 (HIPPA)** is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, the right to understand and control how your protected health information (PHI) is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

1. **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is Dr. Roufaida Al-Misky referring you to a specialist physician.
2. **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing activities, and utilization review. An example of this would include sending your insurance company a bill for your visit.
3. **Healthcare operations** include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service.
4. The practice may also be required or permitted to disclose your PHI for **law enforcement as required by federal, state or local law and other legitimate reasons**. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may **contact you by phone, email, text or in writing**, to provide appointment reminders or your medication at a pharmacy is ready or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**Other ways your health information may be used or shared.** We are allowed or required to share in ways that contribute to the public good, for example research and public health. Many conditions have to be met in the law before we can share this information. <https://www.hhs.gov/hipaa/index.html>

### **Use and disclosure of your PHI in certain special circumstances:**

1. **Public health and safety issues.** Our office may disclose your PHI to public health authorities to maintain vital records, report suspected abuse, neglect or domestic violence, report adverse reactions to medications or problems with products or devices, prevent disease, or prevent or reduce a serious threat to anyone's health or safety or to the public.
2. **Comply with the law.** We will share information about you if state or federal laws require it. Our practice may use and disclose your PHI to a health oversight agency for activities authorized by law. This could include inspections, investigations, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the healthcare system in general. An example is the Department of Health and Human Services to determine if we are in compliance with federal privacy law.
3. **Lawsuits and similar proceedings.** Our practice may share your PHI in response to a court or administrative order or in response to a subpoena.
4. Our practice may release PHI to a **medical examiner, or coroner or funeral director** for a deceased Individual.
5. If you are an organ donor, our practice may release your PHI to **organ procurement organizations** for organ and tissue donation requests.
6. Our practice may use and disclose PHI for **health research** purposes.
7. We may disclose or share health information about you for **workers compensation, law enforcement purposes or to law enforcement officials, or to special government requests** for special government functions such as the military, national security, and presidential protective services.

Other uses and disclosures of PHI not described in this notice will only be made pursuant to us receiving a written authorization from you. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization. Also, a written authorization is required for most uses or disclosures of psychotherapy notes.

**You may have the following rights with respect to your PHI:**

1. The **right to request restrictions on certain uses and disclosures of PHI**, including those related to disclosures to family members, or any other person identified by you, who may be involved in your care or for notification purposes. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it except when required by law, in emergencies or when information is necessary to treat you unless you agree in writing to remove it.
2. The **right to reasonable requests to receive confidential communications of PHI** by alternative means or at alternative locations.
3. The **right to inspect and copy your PHI**.
4. The **right to amend your PHI**. We may ask you to make the request in writing and state the reason. We may so no but will tell you why in writing within 60 days.
5. The **right to receive an accounting of disclosures of your PHI**.
6. The **right to obtain a paper copy of this notice** from us upon request at any time. You can view a copy of this notice on our website [www.familymedicineandwellness.com](http://www.familymedicineandwellness.com) and in the lobby.
7. The right to choose someone to act for you. If a person has the authority to act for you, such as your **medical power of attorney or legal guardian, that person can exercise your rights, and make decisions about your health information**. You or your personal representative may need to provide authorizing paperwork before we can evaluate if the person has this authority and can act for you before we take any action.
8. The **right to be advised if your unprotected PHI** is intentionally or unintentionally disclosed.
9. **The right to limit what information we use or share**. If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
10. You have **the right and choice to tell us to share your information in a disaster situation**.

We will comply with and abide by all applicable state and federal laws. For the state of Michigan there are more limits on the disclosure of HIV and AIDS, substance abuse information and mental health information.

We may participate in a **Health Information Exchange** that allows electronic transfer of PHI between healthcare providers to coordinate treatment.

We are required by law to maintain the privacy and security of your PHI. We must follow the privacy practices described in this notice and to provide you the notice of our legal duties and our privacy practices with respect to PHI.

This notice is effective as of August 1, 2021 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by your office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint. Visit <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>, or write to 200 Independence Ave, SW Washington, DC 20201, or call 1-800-368-1019.

Please contact Dr. Al-Misky at 248-759-0993, or in person or in writing or [info@dralmisky.com](mailto:info@dralmisky.com) with questions or for more information regarding this notice or our health information privacy policies.



## PRIVACY PRACTICES AND CONSENT TO TREAT ACKNOWLEDGEMENT

I certify that I have been issued the HIPPA Notice of Privacy Practices, and I have reviewed it. I fully understand that Family Medicine and Wellness, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services, and conducting health care operations.

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE

I acknowledge Family Medicine and Wellness, PLLC is a Patient-Centered Medical Home and choose to participate. A Patient-Centered Medical Home is a Partnership Between the Patient and his/her Physician.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_  
PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE

### **MEDICAL CARE CONSENT**

I give consent to Roufaida Al-Misky, MD, FAAFP of Family Medicine and Wellness, PLLC to perform and provide medical care, tests, or procedures as agreed upon in the best interest of my health.

*Initial Here* \_\_\_\_\_

### **CONSENT TO OBTAIN PRESCRIPTION HISTORY**

In an effort to improve the quality and safety of our patient care, we may require your current prescription medications. I agree that Family Medicine and Wellness, PLLC may request my current prescription history from third party pharmacy benefit payors for treatment purposes.

*Initial Here* \_\_\_\_\_

### **PAYMENT RESPONSIBILITY**

I authorize Dr. Roufaida Al-Misky to bill my insurance carrier, and when needed to release any medical or personal information that is required to process the claim on my behalf. I acknowledge and agree that I am fully responsible for all costs incurred for my treatment in the office of Family Medicine and Wellness, PLLC. I understand payment and / or copay is preferred on the date of service.

*Initial Here* \_\_\_\_\_

### **CANCELLATION AND NO-SHOW POLICY**

We understand that sometimes it is necessary to reschedule an appointment. We request at least 48 hours notification prior to cancelling and will gladly reschedule. A no show is a scheduled appointment not kept by the patient. For the first instance, we will call or email you to remind you of the missed appointment. For the second instance, you will be charged \$25, and for the third instance you will be charged \$45. We regret any inconvenience this may cause you, but we appreciate your help in keeping an orderly schedule so that we can better serve all our patients.

*Initial Here* \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_  
PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE



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## CONSENT FOR COMMUNICATION VIA E-MAIL

Please print clearly. Check here if you wish to decline consent. \_\_\_\_\_

I, patient name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Hereby consent to have Dr. Al-Misky at Family Medicine and Wellness, PLLC or Family Medicine and Wellness staff members communicate with me, or Family Medicine and Wellness staff, or other physicians, physician assistants, nurse practitioners, other health professionals, and pharmacists via email regarding aspects of my medical care, treatment, test results, prescriptions, appointments, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my practitioner and me or members of my practitioner's office and other practitioners, or pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my practitioner and me or members of the office staff or between my practitioner and other practitioners, or pharmacists regarding my medical care may be printed out and made part of my medical record. I understand that in urgent or emergent situations I should go to the Emergency Room and not rely on e-mail.

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

Signature: \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE