MEDICAL PROCEDURES CENTER P.C.

The Medical Procedures Centers, P.C.

"We treat people, not just problems."

4800 N. Saginaw Rd., Midland, MI 48640 (989) 631-4545
Fax: (989) 631-9949
Visit our websites at: MPCenter.net, VasectomyMichigan.com, soulmedicalspamidland.com

MICHIGAN VASECTOMY CENTER
No Needle, No Scalpel, No Sutures

Lorenzo Berlanga, M.D.

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: _____
City: _____ State: ____ Zip Code: _____ 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: _____
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 physician(s) Name: _____ Address: _____ _____

Describe your overall health condition: Good Fair Poor
Are you or is there a chance you are pregnant? Yes No NA

Recent Hospitalization? Y N
Do you take Blood Thinners? Y N
Have a Pacemaker? Y N

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

	Now	Past	No
Eczema			
Artificial Heart Valve			
Heart Murmur			
Heart Surgery			
Rheumatic Fever			
Lyme Disease			
Heart Disease			
High Blood Pressure			
Circulatory Problem			
Stroke			
Bleeding Tendencies			
Blood Clots			
Asthma			
Emphysema/COPD			
High Cholesterol			
Diabetes			
Arthritis			
Osteoporosis/penia			
Hypoglycemia			
Thyroid Disorders			
Kidney Disorders/Stones			
Enlarged Prostate			
Hepatitis or Jaundice			
Fainting History			
Glaucoma			
Seizures			

	Now	Past	No
Nervous Problems			
Psychiatric Care			
Depression			
Sickle Cell Disease			
Colon Polyps			
Stomach Reflux (GERD)			
Ulcer			
Malignancies/Cancers			
type _____			
when _____			
Radiation/Chemotherapy			
Anemia/Leukemia			
Tuberculosis (TB)			
Exposure to AIDS			
Venereal Disease			
Blood Transfusions			
Drug Abuse			
Alcohol/Abuse _____			
_____			
Medical Marijuana			
Smoker? Amount_____			
Quit? When? _____			
Ever used a tanning bed?			
Breast Lump			
Abnormal Pap Smear			
Unusual Uterine Bleeding			

Drinks per day	0-5	6-10	10 or more

	Now	Past	No
Frequent Headaches			
Visual Changes			
Weight Loss			
Loss of appetite			
Fevers, Sweats			
Chest Pain			
Frequent Cough			
Shortness of Breath			
Ankle Swelling			
Rectal Bleeding			
Hemorrhoid Problems			
Slow Healing			
Change in mole or skin growth			
Genital Warts			
Rash or itching			
Change in Hair or Nails			
Change in skin color			

Other Problems?
Please List: _____
_____
_____

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

List past surgeries: _____

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

List all medications you are taking: _____

Have you been told you need antibiotics before surgery or teeth cleaning? YES NO Fruits & Vegetables? Y N Servings? ____

Do you take: Aspirin? Y N Vitamins? Y N Fish or Extra Virgin Oil? Y N Vitamin D? Y N

PREVENTIVE HEALTH

	Year	Results	Year	Results	Year	Results
Last Cholesterol						
Last Bone Density Test						
Last Pap Smear						
Last Mammogram						
Last PSA (men, prostate)						
Last test for blood in stool						
Last Sigmoidoscopy/Colonoscopy						
Last Cardiac Stress Test						

If born between 1945 and 1965, have you been screened for hepatitis C? Y N
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 (age 65) __13__ 23__
Shingles vaccine (over age 60) _____
HPV (Gardasil) vaccine _____
Self Breast Exam Y N
Safe Sex 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:

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

PHYSICIAN COMMENTS

Is there a family history of someone dying while alseep, drowning, or playing sports? Y N

How well do you tolerate pain? Well OK Poorly

Do you have a tendency to faint? Y N

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 was offered to review a copy of this policy at the Medical Procedures Center, P.C.'s office on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Medical History Update

☐ No Changes If changes, please list:

Health changes: _____

Surgeries: _____

Medications: _____

Other: _____ Rev'd _____

Patient Signature _____ Date _____