Janice H. Alexander, R.N., M.D.

☐ W62 N225 Washington Ave. • Cedarburg, WI 53012 • (262) 376-1150 • Fax (262) 376-1154

(Please Print)

Patient's Name: Miss / Ms / Mrs. _____ Birthdate _____

Email Address _____ Name Change? (Circle) NO YES - Old name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Patient's Address _____ Apartment _____

City _____ State _____ Zip _____

Driver's Lic. # _____

Patient Employer _____ Social Security _____

Address _____

Name of Spouse _____

Spouse's Employer _____ Phone _____

Spouse's Birthdate _____ Social Security _____

PRIMARY Insurance Name _____ CO-PAY _____

Policy Holder's Name _____ Eff. Date _____

I.D. Number _____ Group Number _____

Address _____

Secondary Insurance Name _____

Policy Holder's Name _____ Eff. Date _____

I.D. Number _____ Group Number _____

Address _____

MEDICARE NUMBER with letter _____

IF MINOR OR COLLEGE STUDENT:

Responsible Parent _____

Address if not the same as patient's _____

City _____ State _____ Zip _____

REFERRED BY _____

Primary Doctor _____ Phone _____

Pharmacy _____ Phone _____

Allergies or Sensitivities _____

Blood Type _____

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical / surgical benefits to Janice H. Alexander, R.N., M.D. and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign Here _____ Date _____

Janice H. Alexander, R.N., M.D.

W62 N225 Washington Ave. • Cedarburg, WI 53012 • (262) 376-1150 • Fax (262) 376-1154

Primary Care Physician:
Name _____
Address _____

Today's Date: _____
Patient's Name: _____
Birthdate: ____/____/____ Sex _____ Age _____

PATIENT COMPLETES THIS SECTION

Please use a ballpoint pen to answer all questions in this section. Put a • next to any answer you would like to discuss with the doctor.

A-PATIENT PROFILE

[ ] Married [ ] Divorced [ ] Single [ ] Separated [ ] Widowed
Last school grade completed _____

	Since	Check if
Occupation _____	_____	retired [ ]

Hobbies/Interests _____
Time since last complete medical examination _____

B-HEALTH OF FAMILY

	Good	Poor	Died	If died, note age and cause (include fatal accidents and suicides)
Father	☐	☐	☐	_____
Mother	☐	☐	☐	_____
Brothers/Sisters: _____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
Spouse: _____	☐	☐	☐	_____
Children: _____	☐	☐	☐	_____
_____	☐	☐	☐	_____

B1-GYN - Menarche at _____ LMP ____/____/____ Cycle _____
Flow _____ x days Abnormal Cramps Clots
Contraceptions _____ Hyst./Menopause at _____
Abnormal Bleeding/Spotting Discharge Dyspareunia
Last pap/pelvis: ____/____/____

B2-OBSTETRICAL

Pregnancy Total: _____
Term: _____
Preterm: _____
Miscar./Ab: _____

Mammogram
Date _____
Result _____
_____

D.O.B.	Wt.	Name

C-ILLNESS - If you have had any of the following, check the appropriate ☑. If a blood relative has had any of the following, check the appropriate ⊗. F, M, MGF, MGM, PGF, PGM-Specify Blood Relative _____

☐ ○ Alcoholism	☐ ○ Epilepsy, seizures	☐ ○ Cancer, tumor
☐ ○ Anemia	☐ ○ Glaucoma	☐ ○ High blood pressure
☐ ○ Bleed easily	☐ ○ Heart disease	☐ ○ Ulcer in stomach or duodenum
☐ ○ Diabetes	☐ ○ Stroke	
☐ ○ Drug abuse	☐ ○ Suicide attempt	☐ ○ Nervous breakdown
☐ Depression	☐ Eye problems	☐ Mumps, measles, chicken pox
☐ Eczema, hives, rashes	☐ Phlebitis	
☐ Liver disease, hepatitis, yellow jaundice	☐ Thyroid disease	☐ Rubella, German measles
☐ Lung disease	☐ Venereal disease	☐ Rheumatic fever

COMMENTS: _____
_____

D-IMMUNIZATIONS - Circle those that you have had and enter the year of the most recent if known.
Flu _____ Tetanus _____ Rubella _____
Pneumonia _____

E-HOSPITALIZATIONS/SURGERY - List illness or operations, and approximate year. EXCLUDE NORMAL PREGNANCIES.

_____	_____
_____	_____
_____	_____
_____	_____

F-MEDICINES - List all medicines, birth control pills, or vitamins you take with or without a prescription.

_____
_____
_____
_____

G-MEDICINE ALLERGIES - List all medicines that you are allergic to: _____
_____

PHYSICIAN COMPLETES THIS SECTION

Please use a ballpoint pen to underline positives in sections 1 through 12.
Refer to section numbers in notes at the bottom and back of this page.

1. HEENT - Headache Vision change & last test ____/____/____
   Hearing change Sinus Congestion Swallowing
   Dental problems & last exam: ____/____/____
2. NECK - Swollen glands Stiff Pain
3. RESPIRATORY - Cough
4. CARDIO/VASC. - Chest pain/discomfort Racing heart
   High blood pressure Short of breath during sleep/exertion
   Swollen feet Varicose veins
5. BREAST - Self exams Lump Pain Discharge
6. GI - Nausea Vomiting Pain Stool black/blood
   Change in eating/bowel habits Bleeding
7. GU - Frequency Pain/burning Blood Stone Stress/incontinence
   Start/stop difficulty Prostate trouble Sex difficulty
8. MUSCULO-SKELETAL - Bone or joint Pain/swelling/deformity
9. SKIN - Wart or mole changes Skin problems
10. NEUROLOGICAL - Seizures Trembling Dizziness Memory
    Lose consciousness Behavior change
11. MOOD - Cry often Last time felt well: _____
    Health worries Work/family problems Considered suicide
12. LIFE STYLE - Smoking Alcohol Drugs Sleep Exercise Meals
    Sexual dissatisfaction Appetite Wt. change Job did/will change
    Seat belts Marital problems/changes No. marriages _____
    Family member: illness, disability, social/emotional problem

Notes: _____
_____
_____

PATIENT HEALTH QUESTIONNAIRE-9

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

SCORING FOR USE BY STUDY PERSONNEL ONLY

_0_ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

EPI0905.PHQ9P

I confirm this information is accurate.	Patient's/Subject's initials:	Date:

Cedarburg Family
Wellness & Aesthetics Center

W62 N225 Washington Avenue • Cedarburg, WI 53012
Phone (262) 376-1150 • Fax (262) 376-1154
www.cedarburgfamilywellnessaesthetics.com

30-SECOND QUESTIONNAIRE: COSMETIC MEDICAL TREATMENTS

Please take a few moments to answer the questions below. We are pleased to offer our valued clients the country's most popular non-surgical aesthetic procedures. Let us know if you would like more information on any of these procedures. ***Please return to front desk after completing.***

Would you be interested in Botox Cosmetic wrinkle removing therapy? Yes___ No__
If yes, which facial areas would you be interested in having treated?
Forehead ___ Crow's Feet ___ Frown Lines (between the eyebrows) ___ Other ___

Would you be interested in receiving Laser Skin Rejuvenation treatments?
(a series of safe, effective, non-invasive treatments designed to erase or reduce skin imperfections on either the face, neck, chest or other body areas) Yes ___ No ___
If yes, which conditions are you interested in having treated?
Age Spots ___ Rosacea ___ Sun Damage ___ Spider Veins ___ Broken Capillaries ___ Fine Lines & Wrinkles ___ Enlarged Pores ___ Acne_____ Other ___

Would you be interested in Tightening/Sculpting services for the face or body? Yes ___ No ___
If yes, which areas would you be interested in having treated?
Chin ___ Neck ___ Arms ___ Flanks ___ Abdomen ___ Thighs ___ Saddlebags ___ Bra line ___
Buttocks ___ Chest (men) ___ Calves ___Knees ___

Would you be interested in a FREE Skin Care Consultation? Yes ___ No ___

Would you be interested in Vaginal Rejuvenation to improve dryness, painful urination, more comfortable sex, to make the area look better? Yes_____ No____

Would you be interested in losing up 20# this month with Rapid Medical Weight Loss? Yes___ No_____

☐ Yes! Please contact me with new information on cosmetic procedures, products and specials.

Name _____

Cell Phone: _____

Email: _____