PATIENT INFORMATION

Patient's Name ______________________________Birth Date____________ Age_______

Address___________________________________City___________State_____Zip_______

Social Security #__________________________ Marital Status________________

Authorization to Contact Patient ___Yes ___No Contact Via Email or Phone__________

Phone # ___________________ Voicemail Message Accepted ____ Yes ____No

Email Address___________________ Patient Signature ___________________________

Mary Kay Corporate – 16251 Dallas Parkway, Addison, TX 75001
Phone # 972.687.4221 Fax # 972.687.4284
Mary Kay Mfg. – 1330 Regal Row, Dallas, TX 75247
Phone # 214.905.6221 Fax # 214.905.6284

***Is the reason for your visit due to a work related injury?* Yes______ No ______**

If yes, please contact your Worker's Compensation Coordinator at 972-687-4533 for Corporate or 214-905-6346 for Manufacturing, Southwest, and ASRS.

Pharmacy Name/Location____

Pharmacy Phone #_______________________ Pharmacy Fax # ______________________

Primary Care/Family Physician ____

Phone #______________________________ Fax # ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient acknowledges that he/she has been given the opportunity to review and/or has received a copy of the Privacy Notice of Mary Kay Clinics/InHouse Physicians.

Patient: ____

Signature: ____

Date: ____

The patient named above refused to sign the Privacy Policy acknowledgement.

Physician/Nurse Practitioner: __________________________________Date ______________

HEALTH HISTORY & REVIEW OF SYSTEMS

Name: ___________________________________ **Date of Birth**: _____________________ **Date:** ____________

PAST/FAMILY/SOCIAL HISTORY: (Please list or state NONE.)

Past Surgeries: ___ None

____

____

____

Family Diseases: ___ None

____

____

____

Smoker: ___ Yes ___ No **Alcohol:** ___ Frequent ___ Occasional ___ Never **Pregnant?** ___ Yes ___No
Caffeine: ___Yes ___ No - Cups/cans per day/wk._______________ **Last Menstrual Cycle**__________________
Medications: ___ Yes ___ No If yes, list ____

____

____

Allergies: ___ Yes ___ No If yes, list allergies/reactions - medications/environmental

____

REVIEW OF SYSTEMS: (Please check Yes or No)

Constitutional: Weight Loss ___ Yes ___ No
Weight Gain ___ Yes ___ No
Fever ___ Yes ___ No

Eyes: Glasses ___ Yes ___ No
Contacts ___ Yes ___ No
Glaucoma ___ Yes ___ No
Cataracts ___ Yes ___ No

ENT: Hearing Difficulty ___ Yes ___ No
Ear Infections ___ Yes ___ No
Nose/Throat Problems ___ Yes ___ No

Cardiovascular: Heart Disease ___ Yes ___ No
Hypertension ___ Yes ___ No
Chest Pain ___ Yes ___ No
Shortness of Breath ___ Yes ___ No

Psychiatric Problems: ___ Yes ___ No

Respiratory: Asthma ___ Yes ___ No
Emphysema ___ Yes ___ No
Lung Disease ___ Yes ___ No

Gastrointestinal: Indigestion/Reflux ___ Yes ___ No
Stomach Ulcers ___ Yes ___ No
Genitourinary: Kidney Disease ___ Yes ___ No
Skin: Skin Disorders ___ Yes ___ No

Neurologic: Epilepsy ___ Yes ___ No
Endocrine: Diabetes ___ Yes ___ No
Thyroid Disease ___ Yes ___ No

Lymph/Immunologic: Cancer ___ Yes ___ No
Musculoskeletal Problems: ___ Yes ___ No
Hematologic: Hepatitis ___ Yes ___ No
Jaundice ___ Yes ___ No
Blood Clots ___ Yes ___ No

Please list any other system problems: ___ None
List:

____

____

PREVENTIVE CARE (Please indicate "Not Done" or Date Screening Last Performed)

Cholesterol Screening_________________ Colorectal Cancer Screening-Colonoscopy______________________
Depression Screening _________________ Osteoporosis Screening-Bone Density__________________________
Female-Mammogram Screening_____________ PAP Smear___________ **Male-**Prostate Screening_____________

Patient Signature: ____ Reviewed By: __________________________

A. **Circle "Yes" or "No" to each statement to best describe your food and health habits.**

1. Do you eat at least 1.5 to 2 cups of fruit daily? **Yes** **No**
   (1 cup = a small apple, a large banana, 1 medium grapefruit, 1 large orange, 1 medium pear, 8 large strawberries)

2. Do you eat at least 2 to 3 cups of vegetables daily? **Yes** **No**
   (1 cup = 1 medium baked potato, 2 large stalks of celery, 1 cup cooked or 2 cups raw greens, 12 baby carrots, 1 large sweet potato)

3. Do you eat foods made from whole grains daily? **Yes** **No**
   (Such as whole-wheat bread, oatmeal, or brown rice)

4. Do you eat low/non-fat milk, yogurt or cheese each day? **Yes** **No**
   (Or the equivalent in soy or other alternative calcium-fortified, non-dairy foods?)

5. Do you believe that your daily diet is nutritionally sound? **Yes** **No**

B. **Circle "Yes" or "No" to each statement to best describe your mental health/behavior.**

1. Do you feel you lack energy? **Yes** **No**

2. Are you often irritable, short-tempered, and disappointed in others? **Yes** **No**

3. Is it hard for you to find joy in your life? **Yes** **No**

4. Do you have difficulty sleeping? **Yes** **No**

5. Do you worry excessively? **Yes** **No**

6. Are you suffering from muscle tension? **Yes** **No**

7. Do you experience guilt more often than usual? **Yes** **No**

8. Is it difficult for you to concentrate? **Yes** **No**

9. Are you too busy to do even routine things? **Yes** **No**

10. Do you have a history of any anxiety or depression? **Yes** **No**

C. **Circle "Yes" or "No" to each statement to best describe your fitness.**

1. Are you happy with your overall fitness? **Yes** **No**

2. Do you participate in a physical activity for at least 30 minutes a day? **Yes** **No**

3. How many days/week do you participate in a physical activity/exercise? _________days/week

   Activity____

4. Do you want to improve your fitness level/capacity? **Yes** **No**

5. Do you break a sweat with physical activity at least 3x/wk? **Yes** **No**

Patient Signature: ____ Reviewed By: ___________________________

CONSENT FOR MEDICAL CARE AND WAIVER OF LIABILITY

This document represents an informed consent by you ("PATIENT") to receive medical care from ______________________________________, (Healthcare Provider's Name) a healthcare professional under contract by InHouse Physicians, S.C., Inc. ("IHP"). By signing below you give your informed consent to receive medical treatment by this healthcare professional and release Mary Kay Inc. ("Mary Kay") as described below.

Duration of Consent

This consent will be effective from _________________ (Date of Treatment), unless and until, you revoke it in writing.

Cost

There is no cost to you for services provided by IHP.

Waiver and Release

I, THE PATIENT, ACKNOWLEDGE THAT THE MEDICAL CARE I AM SEEKING IS BEING SOUGHT VOLUNTARILY FROM IHP. I AGREE TO WAIVE AND RELEASE ANY AND ALL CLAIMS, ACTIONS, CAUSES OF ACTION, DEMANDS, EXPENSES, OR LIABILITIES OF WHATSOEVER KIND AND NATURE (INCLUDING WITHOUT LIMITATION, CONSEQUENTIAL LOSS, ATTORNEY'S FEES AND EXPENSES, COURT COSTS, AND COSTS OF INVESTIGATION) AGAINST MARY KAY AS WELL AS ITS EMPLOYEES, AGENTS, OFFICERS AND DIRECTORS, WHICH MAY ARISE OUT OF THE MEDICAL CARE PROVIDED BY IHP, ITS EMPLOYEES, AGENTS, OFFICERS, OR CONTRACTORS.

The above waiver and release is not intended to waive your rights to workers' compensation benefits for which you may become eligible as a result of any work-related injury, nor is it intended to waive your rights to any benefits you or other covered person might have under a company sponsored insurance benefit or medical plan.

Consent and Representations

You hereby represent that you have carefully read the above information regarding informed consent and fully understand the implications thereof. You hereby consent to the conditions outlined above concerning delivery of medical care to you.

PATIENT: ____

DATE: ____

WITNESS: ____