PATIENT MEDICAL HISTORY & DISCLOSURE

Date _____ Ethnic Group: Black / White / Asian / Hispanic / Bi-Racial / Other (please list) _____

Name _____ Please State Country of Origin _____

Address _____ Religious Preference _____

City _____ State _____ Referred by(if by yellow pages please list which city) _____

County _____ Zip Code _____ Insurance Company _____

Home Phone (___)_____ Date of Birth _____ Age ____ Education: 6 7 8 9 10 11 12 13 14 15 16 • Marital Status: M S W D Sep
(circle highest grade completed)

TO THE PATIENT: It is very important that you fill in this form COMPLETELY AND ACCURATELY, INCLUDING ADDRESS, PHONE NUMBER, DATES, ETC. Your treatment here today depends on this, and we need a complete and accurate medical history in order to give you proper care. ALL OF OUR RECORDS ARE CONFIDENTIAL!

PREGNANCY HISTORY

_____ Total number of previous pregnancies
_____ Number of full-term deliveries
_____ Number of premature deliveries
_____ Number of living children

Dates of deliveries _____
_____ Number of miscarriages
_____ Number of abortions
_____ Date of last abortion

Complications with pregnancies, deliveries, miscarriages, or abortions: (Explain) _____

YES	NO	
_____	_____	Pelvic examination. If so, when (most recent)?
_____	_____	Have you ever had a Pap Smear? Date of last one _____ Normal ( ) Abnormal ( )
_____	_____	History of abnormal Pap Smears? If so, what class and how was it treated? _____
_____	_____	Vaginal infection (yeast, etc. or STD (Sexually Transmitted Disease: Chlamydia, Herpes, HIV, Vaginal warts, Trichomonas, Gonorrhea, Syphilis, etc.) When? _____
_____	_____	PID (Pelvic Inflammatory Disease) or infection of the uterus or fallopian tubes? When? _____
_____	_____	Discharge from your vagina now? If so, color _____ odor _____ itching _____
_____	_____	Cancer of the uterus, cervix or vagina?
_____	_____	Breast mass, lumps, discharge or breast cancer?
_____	_____	Breast feeding now?

MEDICAL HISTORY

Check if you have ever had any of the following:

YES	NO	
_____	_____	ALLERGY or PROBLEMS with drugs (example; Penicillin, Tetracycline, Antibiotics, Novocaine, Lidocaine, Aspirin, Iodine, Betadine, X-ray dye, Valium, Librium, Tranquilizers, Codeine, pain killers, other)? If yes, what drug?_____
_____	_____	ALLERGY to fish or shellfish, avocados, water chestnuts, any other foods or latex or condoms? Please list: _____
_____	_____	Taking medications/drugs now? If yes, what? _____
_____	_____	Have you taken any Xanax, Valium, Librium, Centrax, Halcyon, Ativan, or other tranquilizers or sleeping pills in the last six months? When?_____
_____	_____	Smoke cigarettes? _____ Packs/day _____ For how long?
_____	_____	Drink alcohol? _____ How much/day _____ For how long?
_____	_____	1. Have you ever been hospitalized? Please include childbirth. _____ Please give date/reason _____
_____	_____	2. Have you had any outpatient surgeries (example: D&C, cervical cautery, laser surgery, etc.)? Please give date/reason _____
_____	_____	3. Have you ever had a blood transfusion? Please give date/reason _____

Check if you have now or have ever had any of the following:

YES	NO		YES	NO		YES	NO	
____	____	Heart Murmur	____	____	Cancer	____	____	High Blood Pressure
____	____	Mitral Valve Prolapse	____	____	Liver Disease	____	____	Sickle Cell Anemia
____	____	Heart Disease	____	____	Hepatitis	____	____	Sickle Cell Trait
____	____	Rheumatic Fever	____	____	Ulcers	____	____	Blood Clotting Disorder
____	____	Are you Rh negative?	____	____	Varicose Veins	____	____	Thyroid Disease
____	____	Kidney Disease	____	____	Thrombophlebitis	____	____	Gallbladder Disease
____	____	Bladder Infection	____	____	Phlebitis (infected veins)	____	____	Severe Depression
____	____	"Cold or Flu" now	____	____	Migraine: Headaches	____	____	Psychiatric Care
____	____	Pneumonia	____	____	Epilepsy	____	____	Drug Addiction or Abuse
____	____	Tuberculosis	____	____	Seizure Disorder	____	____	Problems with Anesthesia
			____	____	Asthma	____	____	Diabetes

Is there any other medical information?_____

I have fully and completely told my past and present medical history, including prior surgery, allergies, blood conditions, present/prior medications and drugs taken, and reactions I have had to anesthetics, medicines or drugs. I have read and fully understand the PATIENT MEDICAL HISTORY & DISCLOSURE. The information I provided therein is complete and accurate.

_____
(Patient's Signature)

A Capital Women's Health Clinic

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____ Signature_____ Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.