Women's Health of Oregon

CONFIDENTIAL MEDICAL HISTORY UPDATE

Date: _____ Name: _____ DOB: _____

Preferred Name: _____ Primary Care Provider: _____

Have you had any of the following tests since your last visit? If yes, please indicate <u>DATES</u>.

Pap Smear: _____ Mammogram: _____ Colonoscopy: _____ Surgery: _____
Bone Density Scan: _____ Blood Sugar Level: _____ Cholesterol Panel: _____

Vaccinations: Flu: _____ TDAP: _____ Shingles: _____ COVID: _____ # of doses_____
brand

MEDICATIONS/SUPPLEMENTS: () NONE

Medication Name and Dose Instructions Prescribed by

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Changes to Personal or Family Medical History: () YES () NO If yes, please list:

_____

_____

Last Menstrual Period (First day) _____ Was this a normal period? () YES () NO

What is your current form of birth control? _____ (pills, condoms, vasectomy, ect.)

Do you desire to change your birth control method? () YES () NO

Social History:

() Single () Married () Partnered () Divorced () Separated () Widowed

Do you feel safe in your current relationship? () YES () NO

Have you experienced any of the following: Sexual abuse: () YES () NO Emotional abuse: () YES () NO

Trauma: () YES () NO If yes, () current or () past

Number of sexual partners in the last: 1 year _____ 3 years _____

How often do you exercise? () None () Active but no formal exercise () Once a week or less () One to three times a week () Four or more times per week

Do you use any of the following?

Alcohol**:** () YES () NO If yes, # of drinks per week? _____ Caffeine: () YES () No If yes, # of drinks per day? _____

Tobacco: () YES () NO () NEVER If yes, # cigarettes per day _____ age started _____ age quit _____

Recreational Drugs: () YES () NO If yes, I use_____, how often_____

Are you <u>currently</u> experiencing any of the following symptoms?

Please mark the circle if you are.

Constitutional

() fever
() chills
() sweats
() weight change - gain or loss
() weakness
() fatigue

Eyes
() change in vision

Ears, Nose, Mouth, or Throat
() change in hearing
() nose bleeds
() sore throat
() dry mouth

Cardiovascular
() dizziness
() shortness of breath
() chest pain
() loss of consciousness
() palpitations

Respiratory
() cough – productive or dry
() wheezing

Gastrointestinal
() abdominal pain
() nausea, vomiting
() change in bowel habits
() change in appetite
() dark or bloody stool
() indigestion
() constipation or diarrhea
() bloating for more than 30 days

Hematologic / Lymphatic
() swollen lymph glands
() bruise easily

Gynecological
() bleeding or pain with intercourse
() unusual vaginal discharge or odor
() vulvar or vaginal itching
() pelvic pain
() bleeding after menopause

Musculoskeletal
() back pain
() weakness
() joint pain, stiffness, swelling

Urinary
() painful urination
() frequent urination
() urgency
() blood in urine
() urinary incontinence
() getting up at night to urinate

Integumentary / Breast
() nodules
() change in moles, freckles
() change in hair – growth, loss texture
() lumps
() nipple discharge
() pain

Neurological / Psychiatric
() numbness or tingling
() memory change
() depression
() anxiety
() mood swings

Endocrine
() excessive thirst
() tremor
() sleep disturbances
() cold or heat intolerance
() hot flashes
() night sweats

() **NO** current symptoms

What health concerns/ problems do you wish to discuss today? _____

_____

Thank you for carefully filling this out,

We appreciate you.

Women's Health of Oregon

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First and last name (no middle or nickname): _____

Mailing Address: _____

City: _____ State: _____Zip Code: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____Email: _____

Ethnicity: _____ (Hispanic, Non-Hispanic, Unknown) Primary Language: _____

Employer: _____ Occupation: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____Phone: _____

Referred by: _____ Primary Care Doctor: _____

Preferred Pharmacy (name and city)_____

INSURANCE INFORMATION

Please provide insurance card(s) and a photo ID at time of appointment.

Authorization for use/disclosure of health information:

I understand that I am responsible for charges not covered by my insurance. Any additional services through outpatient labs, radiology, pathology, etc. will be billed separately by those providers in addition to services rendered by Women's Health of Oregon. I give my permission to disclose information to my insurance company and to other treating providers for the sole purpose of continuity of care, preauthorization and claim processing for medical care. I acknowledge that it is my responsibility to obtain a referral from my primary care physician if it is required by my insurance policy and I will advise Women's Health of Oregon of any changes to my coverage. If I am uninsured at the time of service, I will make arrangements with the financial counselor for a payment plan to Women's Health of Oregon. Outside service vendors will make their own arrangements for payments.

I have read this disclosure and voluntarily authorize and direct my health care provider for Women's Health of Oregon to provide my medical care.

Signature: _____ Date: _____

Informed Consent

Disclaimer of Liability

Agreement to Pay for a Non-Covered Service or Item

This form must be completed in full before providing services or items to a client.

I, _____ (print name) understand that anything my insurance does not cover I will be responsible for. I further understand I am personally responsible for the financial charges, should I choose to obtain the service(s). This includes the $100 no show fee for appointments cancelled less than 24 hours ahead of time.

In the event that my medical coverage is not in effect, if I do not have a referral for today's services (if required), or I cannot provide proof of eligibility, then I am financially responsible for these charges.

I understand that payment is expected in full at the time of billing. Some rare cases may qualify for a payment plan not to exceed three months.

I agree to be financially responsible for the service(s) I receive today, including but not limited to physician services, lab, and diagnostic imaging.

I am aware that I am fully responsible for knowing my insurance benefits, that the clinic is not responsible for telling me.

THE CLINIC DOES NOT CHECK INSURANCE BENEFITS

_____ _____

Signature of Patient or Responsible Party Date

Women's Health of Oregon, LLC

Medical Information Release Form

(HIPAA Privacy Authorization)

NAME (PRINT): _____ DATE OF BIRTH: _____

AUTHORIZATION TO LEAVE DETAILED VOICEMAIL:

YES ____ phone number: _____

NO ____

RELEASE OF INFORMATION:

I authorize **WOMEN'S HEALTH OF OREGON** to disclose protected health information described below to:

□ spouse (name) _____

□ parent (names) _____

□ other (names) _____

EXTENT OF AUTHORIZATION:

PLEASE CHECK ONE

□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse, consultations, and billing or claims.)

OR

□ I authorize the release of my complete health records EXCEPT the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

Signature of patient:_____ Date:_____