LAS VEGAS PAIUTE TRIBE
HEALTH AND HUMAN SERVICES

PATIENT BILL OF RIGHTS

All Patients at the Las Vegas Paiute Tribe Health and Human Services Department Clinic are entitled to respect and dignity. They have a right to health care that is considerate, respectful and culturally sensitive. Your Patient's Rights are as follows:

Privacy and Confidentiality:
The right to privacy and confidentiality concerning medical records, treatments, examinations, case discussions, case presentation and other information. The patient has the right to refuse the presence of and limited treatment by heath care students.

Personal Safety:
The right to expect reasonable safety insofar.as the health clinic's practices and environment are concerned.

Identity:
The right to know the name and qualifications of the persons(s) who will be responsible for his or her treatment.

Information Disclosure:
Patients have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

Consent:
The right to be informed of the medical procedures and treatments. The physician must provide all information necessary for the patient to make a decision as to whether the procedure or treatment is acceptable, including an explanation of the risk involved, whether or not any incapacity for normal living will result and if there is any alternative forms of treatment. In Life Threatening Emergency situations, the physician would not be responsible for providing extensive information if it would further jeopardize the wellbeing of the patient.

Consultation:
The patient has the right at their own expense to seek and consult with private health care professionals.

Refusal of Treatment:
The right to refuse treatment to the extent provided by the law. If health care services are refused, the patient must be informed of the risks incurred by doing so. The patient is responsible for any deterioration of their health condition when treatment is refused and health care provider's instructions are not followed. If a minor refuses treatment, the designated/legal representative must be told of the risks incurred if treatment for the minor is refused.

Transfer Continuity of Care:
When Health Care Services are not available at our clinics, the patient and their designated/legal representative will be informed about the availability of specialized care at another center/clinic/hospital. The patient has a right to expect reasonable referrals for continuity of care for his or her condition or illness.

PATIENTS RESPONSIBILITIES

Your care depends partially on you. Therefore, in addition to your "Patient Rights," you have certain responsibilities as well, you may be dismissed from care or refused care if you do not adhere to them. These responsibilities are presented to you in the spirit of mutual trust and respect.

1. Provide to the best of your knowledge, accurate and complete information about present symptoms, past illnesses and hospitalizations, medication usage and other matters relating to your health.
2. Follow the treatment plan as recommended by your provider.
3. Report unrepentant changes in your medical condition to your provider.
4. Understand your course of treatment, including pain relief options, as outlined by your provider, nurse and other health care providers.
5. Keep your scheduled appointments with the health care providers and always notify them within **24 hours** if you are unable to keep your appointment.
6. Please arrive **15 minutes** early prior to your appointment for proper filled paperwork. If you will be **15 minutes** late we will re-schedule your appointment.
7. Your conduct at each visit to the Clinic will remain appropriate at all times, including during your Clinic appointment.
8. Take the responsibility for all consequences if you refuse medical treatment or do not follow provider's orders or instructions.
9. Assure that your financial obligations to the Clinic and your health care providers are fulfilled as promptly as possible.
10. Follow all Clinic rules and regulations affecting your care.
11. Be considerate of the rights, privacy and property of other patient, visitors and Clinic staff.
12. Provide the Clinics with a copy of your written directives if available.
13. You will not consume any drugs, alcoholic beverages or toxic substances before or during your medical appointments in our clinic.
14. If your conduct and behavior is disruptive, the Las Vegas Tribal Police will be contacted to escort you off the Clinic property.
15. If your conduct continues to be disruptive to others during your Clinic visit, the Clinic can temporary or permanently discontinue providing services.

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Las Vegas Paiute Tribe Health & Human Services

WHY WE ASK QUESTIONS

Privacy Act Notification Statement of the Las Vegas Paiute Tribe Health & Human Services

BENEFITS

Reasons why Las Vegas Paiute Tribe Health and Human Services (LVPTHHS) and Purchase Referred Care (PRC) need to collect information from and about you:

- find out how you feel or what you think is wrong;
- To find out if a member of your family has a condition that could affect your health;
- To locate your health record among all the others;
- To reach you and your family (for follow-up care or to mail medical test results or future appointments to you) to maintain your health;
- To determine your health condition and the kind of care that is right for your health;
- If you give complete and correct information to the best of your ability then LVPTHHS staff will be better able to decide what proper care is needed.

USES

LVPTHHS personnel will not reveal to anyone what is in your health record without your written permission, except to:

- State, local or other authorized groups to provide health service to you or to reimburse contractors for the services provided to you.
- Federally approved or healthcare oversight organizations that evaluate the health care you receive
- Persons performing health related research projects, which have been approved by the LVPTHHS
- Tribal, State or Federal government agencies which by law requires the information for the purposes of law enforcement, birth and death reporting and communicable disease control
- Local schools for the purpose of providing health care to the children they teach
- Organizations (Medicare/Medicaid, insurance companies) for them to reimburse LVPTHHS and contract health service providers for services provided to you.

ELIGIBILITY

Information is required if we are to determine:

- Your eligibility to receive health care from the LVPTHHS;
- Your eligibility based on proof of enrollment or decent of a federally recognized Native American tribe;
- Your eligibility based on proof of residency (rent/utility receipt).

LAST RESORT

Other information is required if we are to determine:

- Your eligibility to have other agencies such as Medicare, Medicaid or private insurance companies pay LVPTHHS for part or all of your health care expenses;
- Your eligibility to receive health care from other organizations (such as the Veterans Administration).

These requirements are contained in 42 CFR Section 36.12 and 42 CFR Section 36.23. These regulations say that LVPTHHS is to obtain information on possible use of other health resources which may be used to provide you with health care. This information is to be obtained before health care is provided to you directly by LVPTHHS or by contract health providers.

AUTHORITY

Records of health care provided to you are maintained by LVPTHHS under the following laws:

- Public Health Service Act, Section 321
- Indian Self-Determination and Education Assistance Act;
- Snyder Act
- Indian Health Care Improvement Act;
- Construction of Community Hospital Act
- Indian Health Service Transfer Act.

DISCLOSURE

LVPTHHS EMPLOYEES ARE REQUIRED TO KEEP A LIST OF PEOPLE TO WHOM THEY RELEASE INFORMATION FROM YOUR HEALTH RECORD. YOU HAVE A RIGHT TO SEE THAT LIST. THE LIST MUST SHOW WHAT WAS RELEASE, TO WHOM (NAME AND ADDRESS), FOR WHAT PURPOSE AND THE DATE OF RELEASE. YOU MAY SPEAK WITH A PERSON AT THE FRONT DESK TO FIND OUT HOW TO DO THIS.

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights to your protected health information, which you can exercises by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- File a complaint.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 1, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a complaint:

Las Vegas Paiute Tribe Health & Human Services
(Acting Privacy Officer)
1257 Paiute Circle
Las Vegas, NV 89106
(702)382-0784

Chart Number _____

FILL OUT THIS FORM COMPLETELY

PATIENT REGISTRATION *Confidential*

When did you move to Clark County? _____ Social Security # _____ - _____ - _____

Legal Name of Patient: _____ ○ Male ○ Female
(Last) (First) (Middle)

Other Names Used: _____ Religion: _____

Birth Date: ____/_____/_____ Place of Birth: City: _____ .State: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: _____
(Street or Box Number) (City/State) (Zip)

Home Phone: _____ Cell Phone: _____ Message Phone: _____

Employer: _____ Employer Phone: _____ Employer Address: _____

Internet Access? ☐ Yes ☐ No If YES, Where? ☐ Home ☐ Work ☐ Mobile ☐ School **E-Mail Address**: _____

Total in Household: _____ Total Household Income: _____ / ☐ Bi-Weekly (☐ Monthly (☐ Weekly (☐ Yearly

Primary Language: _____ Secondary Language: _____ Interpreter required? ☐ YES ☐ NO

Are you a Veteran? ☐ Yes ☐ No Branch: _____ Entry Date: _____ Discharge Date: _____

Are You An Enrolled Member Or A Descendant Of A Federally Recognized Tribe In The United States? ☐ YES ☐ NO
Tribe of Membership: _____ Tribe Quantum: _____ Total Blood Quantum: _____ Enrollment#: _____

FATHER'S Full Name: _____ Birthplace: _____ Tribe (Federally Recognized) _____

MOTHER'S Full Name: _____ Birthplace: _____ Tribe (Federally Recognized) _____
(Maiden)

Emergency Contact: _____ Address: _____ Relationship: _____ Phone: _____

Next Of Kin: _____ Address: _____ Phone: _____ Relationship: _____

HEALTH INSURANCE INFORMATION -BRING YOUR CARD TO EVERY VISIT!

Do You Have Medical Insurance? ☐ Yes ☐ No Pharmacy Insurance? ☐ Yes (☐ No

Type Of Coverage: ☐ Medicaid/NV Check-up ☐ Medicare B ☐ Private Insurance (Continue Below)

Name Of Health Insurance: _____ Health Insurance Phone#: _____

Policy# of Insurance _____ DATE Eligibility Began: _____

Policy Holder Name: _____ Policy Holder's DOB: _____ Policy holder's S.S.# _____-_____-_____

Patient Relationship To Holder: ☐ Self ☐ Spouse ☐ Child

Employer's Address: _____ Phone#: _____

I CERTIFY THE ABOVE INFORMATION TO BE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE THE LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICES TO VERIFY THE ACCURACY OF THIS APPLICATION.

_____ Date: _____
PATIENT SIGNATURE (Parent or Guardian if under 18)

Office Use Only ****Documents Must Be Provided At The Next Office Visit Or Within 30 Days Of Registering****

RECV'D	NEED		RECV'D	NEED	
_____	_____	Tribal Enrollment/Descendant	_____	_____	Birth Certificate
_____	_____	Drivers License Or Picture Id	_____	_____	Proof Of Residency-Rent/Utility Receipt
_____	_____	Private Insurance Information	_____	_____	Medicare And/Or Medicaid Information
_____	_____	Social Security Card~~~~~~~~~~~~~~Visually Verified/Staff Initial _____			

CONSENT FORM

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date:**_____

Signature: _____ **Relationship to Patient:** _____

Uses and Disclosures for TPO may be permitted without prior consent in an emergency

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I wish to be contacted in the following manner,
Check all that apply:

Home Telephone
◯ Ok to leave messages with detailed information.
◯ Leave messages with call back number only.

Work telephone
◯ Ok to leave messages with detailed information.
◯ Leave messages with call back number only.

◯ Other: _____
_____

Written communication
◯ Ok to mail to my house address
◯ Ok to email me.

Referral pick-up
◯ Ok to be released to designated person
◯ At my verbal request
◯ NOT to be released to any person other than myself.

Signature: _____ Date: _____/_____/_____

****OFFICE USE ONLY****

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement*, but was unable to do as documented below:

Date: _____/_____/_____ Initial: _____ Reason: _____

In order to provide our patients with the highest quality medical service and support ethical standards through reliability and integrity of health data the Las Vegas Paiute Tribe Health & Human Services can offer Medical or behavioral Healthcare advice and/or treatment VIA telephone on a case by case basis, in effort to ensure continuity of patient care.

If you require emergency/urgent care, please call 9-1-1. If you require medical/behavioral care from a provider, please contact the Las Vegas Paiute Tribe Health & Human Services during regular business hours, Monday-Friday, between the hours of 8:00 AM to 5:00 PM for an appointment.

DIRECT CARE

This Form Contains Important Information Regarding Your Health Care.

WHO is Eligible?

To be eligible for Direct Care Services you must be a member or descendent of a federally recognized Native American Tribe in the United States.

WHAT Services Are Provided?

Direct Care Services are primary health care services provided by the professional staff of the Las Vegas Paiute Tribe Health & Human Services (LVPTHHS). Primary medical and behavioral health care services are provided at no cost to you. Please note a referral form must be obtained for each doctor or provider visit even if it is on the same day.

A FEE is charged by LVPTHHS for the following:

- Clinic Pharmacy: There is a charge for pharmacy medications.
- Any laboratory or diagnostic testing performed **within** LVPTHHS clinic
- Optical materials, lab fees, and service
- Dental material, lab fees, and service

Medical, drug, vision or dental insurance may offset some or all cost share.

LVPTHHS providers may refer you to a specialist for further medical care.
LVPTHHS is not responsible for payment for services received at any other medical facility including and not limited to:

- Specialist office visits, Laboratory testing, radiology services and diagnostic testing

I have read the above and understand that payment is due at the time services are rendered._____ Initials

If you have Health Insurance(Nevada Medicaid, Medicare, or Private Insurance), your insurance will be billed for services provided at LVPTHHS clinic.

If you do not have insurance or cannot pay for additional services, you may access the **Moapa Paiute Indian Clinic, Parker Indian Health Center or Phoenix Indian Medical Center** for management of your medical condition. These facilities are funded to provide full medical coverage for all Native Americans.

Your care depends partially on you. Therefore, in addition to your "Patient Rights" you have certain responsibilities as well. These responsibilities are presented to you in the "Patient Bill of Rights and Patient Responsibilities" page. You may be dismissed or refused care if you do not adhere to them. _____ Initials

Patient/Parent/Guardian: _____ Date: _____
Signature

Guarantor of Payment/Responsible Party: _____

Relationship to Patient: _____

Witnessed LVPTHHS Staff: _____ Date: _____
Signature

LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICE
1257 Paiute Circle Las Vegas, NV 89106
Telephone: (702) 382-0784 Fax: (702) 384-5272

Assignment of Benefits Form

I, _____ (Print Name) hereby assign and convey directly to the above named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above named health care provider, regardless of its managed care network participation status, in-network or Out-Of-Network. **I hereby certify that the insurance information that I have provided is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full**. I also understand that my insurance company may not pay 100% of the amount of the medical claim. I understand that I may be financially responsible for all charges not payable by my insurance company.

I hereby authorize the above named health care provider to submit claims. on my behalf and to release all medical information necessary to process my claims to any insurance company, adjuster. governmental agency or attorney involved in this case. I hereby authorize my insurer to assign and transfer any and all applicable plan benefits and rights to provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific plan are administered accurately, including the right to receive any applicable relevant, plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf and remedies due under any Title XVIII of the Social Security Act, related provisions of Title XI as well as Federal, City or State Government program. This authorization includes any and all other rights permissible under state and federal laws, as well as entitled plan programs. This is a direct assignment of my rights and benefits under this plan/policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits at the stated plan benefit level directly to Provider listed above for all entitled benefits related to services rendered. I understand under applicable ERISA. state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERISA regulations hereby instruct and direct my Insurance Company to provide SPD (Summary Plan Description) documentation stating such non-assign ability clause to my-self and Provider listed above. Upon proof of non-assign ability documentation I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional, dental, or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. **I agree and understand that any funds sent directly to me by my insurance company for services rendered by the Las Vegas Paiute Health & Human Services will be immediately signed over and sent directly to the Las Vegas Tribe Health & Human Services within 30 days of receiving said funds.**

Unless revoked, this assignment is valid for all administrative and judicial reviews under the Patient Protection and Affordable Care Act, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ Date: _____
Signature of Patient/Guarantor

BELOW TO BE FILLED OUT BY OFFICE STAFF ONLY

1.Insurance Verification: PPO(name)_____ HMO (name)_____ Other: _____
2.Pharmacy Insurance Billable YES____ NO _____
3.Nevada Medicaid Card, copy of current month YES____ NO____
Verified by: _____ Date: _____

****** COPY GOES TO BILLING OFFICE******

Name: _____ D.O.B: _____ HRN: _____

Have you ever had any of the Medical Condition(s) listed below?
Please Check **ALL** that applies to you.

☐ Measles (10 day)	☐ Mumps	☐ Whooping Cough
☐ Measles (3 day)	☐ Chicken Pox	☐ Sex not satisfactory
☐ Scarlet fever (Scarlatina)	☐ Food, chemical or drug poisoning	☐ Chest pain or angina pectoris
☐ Diphtheria	☐ Received blood or plasma transfusions	☐ Spitting up of blood
☐ Pneumonia	☐ Broken or cracked bone(s)	☐ Night sweats
☐ Influenza	☐ Concussion or head injury	☐ Shortness of breath
☐ Pleurisy	☐ Knocked unconscious	☐ Palpitations or fluttering heart
☐ Any eye disease, injury, impaired sight	☐ Dislocations	☐ Heart Murmur
☐ Any ear disease, injury, impaired heating	☐ Severe Lacerations	☐ Swelling of hands, feet or ankles
☐ Any trouble with nose, sinuses, mouth throat	☐ Recent sprains	☐ Extreme tiredness or weakness
☐ Problems with your teeth	☐ Frequent Infection or bolls	☐ Varicose veins
☐ Rheumatic Fever	☐ Hay fever or Asthma	☐ Albumin, sugar, blood or pus in urine
☐ Rheumatism	☐ Hives	☐ Difficulty urinating
☐ Any bone or joint disease	☐ Eczema	☐ Get up at night to urinate
☐ Neuritis or Neuralgia	☐ Fainting Spells	☐ Abnormal thirst
☐ Bursitis, Sciatica or Lumbago	☐ Convulsions or Seizures	☐ Stomach trouble or ulcer
☐ Stiff, swollen or painful joints	☐ Frequent or Severe Headaches	☐ Colitis or other bowel disease
☐ Polio or Meningitis	☐ Dizziness	☐ Liver or gallbladder disease
☐ Bladder or Kidney Infection or Stones	☐ Anxiety/Tension	☐ Hemorrhoids
☐ Gonorrhea, Syphilis, or Herpes	☐ Difficulty remembering or concentrating	☐ Rectal bleeding
☐ Chlamydia, Venereal Warts	☐ Difficulty sleeping	☐ Constipation or diarrhea
☐ Anemia	☐ Frequent crying spells	☐ Black bowel movements
☐ Yellow jaundice or Hepatitis	☐ Work or family problems	☐ Change in bowel or bladder habits
☐ Tuberculosis	☐ Thoughts about committing suicide	☐ Indigestion or difficulty swallowing
☐ Mononucleosis	☐ Nervous breakdown	☐ Change in a wart or mole
☐ Diabetes	☐ Paralysis or Numbness	☐ Hoarseness or Cough
☐ Hypoglycemia	☐ Enlarged thyroid or goiter	☐ Non-healing sores
☐ Blood Pressure	☐ Enlarged glands	☐ Lumps in breast or elsewhere
☐ Low Blood Pressure	☐ Skin problems	☐ Unusual bleeding or discharge
☐ Cancer	☐ Recent change in appetite or eating habits	☐ Tubal infection

EXPOSURES: Have you been exposed to:
□ Lead □ DES
□ Asbestos □ Others (chemicals, noise, etc.)

ALLERGIES: Are you allergic to:
□ Penicillin, Sulfa, other Antibiotics □ Aspirin, Codeine, or Morphine □ Any other Medication(s) List: _____
□ Insect bites or stings
□ Food(s) List:. _____

MEN ONLY:

Have you ever had swellings of or lumps on testicles? □YES □ NO Do you do regular testicular self-exam? □YES □NO

WOMEN ONLY:

Do you do regular breast self-exam? □YES □ NO
Menstrual History:
Age of onset: ____ Date of last period: _____
Cycle (from start to start): ___ days
Usual duration of flow: _____ days
Flow is: □Heavy □Medium □ Painful □Cramps □Light
Have had vaginal infections or frequent discharge: □Yes □No
Have taken birth control pills or an IUD: □Yes □No
Have had abnormal PAP: □Yes □No Date of last PAP: _____

Pregnancy History:
Number of Pregnancies: _____
Number of children born alive: _____
Number of stillbirths: _____
Number of premature births: _____
Number of miscarriages: _____
Number of abortions: _____
Number of Cesarean Sections: _____

NOTE: **Your medical history will be kept confidential and will remain in the office. Information contained here will not be releases to any person(s) except when you have authorized us to do so.**

Date: _____ **Self and Family History** **HRN: _____**

Name: _____ DOB:_____

Please complete **ALL** sections below.

Hospitalizations: List all, for illness or surgery, beginning with the most recent.

Date	Reason	Hospital	Physician

Medications:

Previous: check all you have used

□ Laxatives □Aspirin □ Vitamins □ Tranquilizers □ Hormones □ Antacids □ Cold/Allergy Pills □Birth Control □ Decongestants □ Nasal Sprays Cortizone □ Diet pills □ Diuretic/Water Pills

Current list all medication(s) you are currently taking with dosage and frequency below

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Date of Last:

Physical Examination: _____ Pap Smear: _____

Cholesterol: _____ Stool Test (Blood): _____

Mammogram: _____ EKG (or Treadmill): _____

Sigmoidoscopy: _____

X-Rays: Have you had any of the following

Chest: Date: _____ Results: _____

Colon: Date: _____ Results: _____

Stomach: Date: _____ Results: _____

Others: _____ Date: _____ Results: _____

Family Member	Age	Health Status	Age	Cause
Father:				
Mother:				
Sibling:				
Sibling:				
Spouse:				
Child				
Child				

Has any blood relative had any of the following?

Disease	Symptom	Relationship	Disease	Symptom	Relationship
Allergies			**Stroke**		
Asthma			**Epilepsy/Seizures**		
Arthritis			**Substance Abuse**		
Glaucoma			**Depression/ Emotional**		
Cancer			**Suicide**		
Tuberculosis			**Kidney Trouble**		
Diabetes			**Birth Defects**		
Heart Trouble			**Sickle Cell Anemia**		
High Blood Pressure			**Mental Retardation**		