Infectious Diseases Consultants of Oklahoma City — Patient Information

**Please complete all information*

Name ______________________________ M F ___/___/___ ______
First Middle Last Sex DOB Age

Address ______________________________
Street Address City State Zip

Home Phone ( ) - ________ Cell Phone ( ) - ________ Social Security # - -

Patient Employer ______________________________ Job Title ______________

Employer's Address ______________________________ Employer Phone ( ) -
Street Address City, State Zip

Email ______________________________

Emergency Contact Name :______________________ Phone: ______________________

Responsible Party

Name ______________________________ Social Security # - -

Address ______________________________ Phone ( ) -
Street Address City, State Zip

Employer ______________________________ Occupation ______________

Employer Address ______________________________ Employer Phone ( ) -
Street Address City, State Zip

Health Insurance Information

Insurance ______________________ Policy Holder : ______________________
Policy Holder Name **Soc Sec #** **Date of Birth**

Policy # ______________________ Group # ______________________

Are you claiming this as an on-the-job injury? □ Yes □ No Date: ______________

Was the problem caused by an accident? □ Yes □ No Date: ______________

Do you have an attorney handling this claim? □ Yes □ No Whom: ______________

Were you referred to our office? □ Yes □ No By whom: ______________

Primary Care Physician Name:______________________ Phone Number: ______________________

Required Authorizations

**Please take a moment to complete all of the following required consents*

Benefits to Physician*:* I hereby authorize payments directly to Infectious Diseases Consultants of Oklahoma City of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (patient or parent of minor) ______________________________

Release of Information*:* I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signed (patient or parent of minor) ______________________________

I have received a Notice of Privacy Practices from the office of David Chansolme, MD.

Signed ______________________________ Date ______________

I have signed the patient consent for use and disclosure of protected health information from the office of David Chansolme, MD.

Signed ______________________________ Date ______________

HIPAA) I authorize practice/billing company to contact me about my bill by reaching me via (Note: If all boxes are checked "no" we will require prepayment on all services)
Phone: yes □ no □ Cell phone: yes □ no □ Work phone: yes □ no □ Mail: yes□ no □

You may speak with the following person/s about my bill regarding medical services provided:

Name ______________________ Relationship ______________________ Phone ( ) -

You may not speak with the following person/s about my bill regarding medical services provided:

Name ______________________ Relationship ______________________

Infectious Diseases Consultants of Oklahoma City

- **David Chansolme, MD, PC**
- **Nestor M. Quezada, MD**
- **Andrea R. Norris, DO**

You have come to the office of an infectious diseases physician because you have symptoms or a diagnosis where specialized care may be required. We have created this information sheet to acquaint you with our standard policies. We suggest that you keep your copy of this sheet to refer to in the future.

Office hours . . .

Our office is open Monday through Friday from 8:30 am until 4:30 pm, excluding holidays. We close for lunch between noon and 1:00 pm. The phones are answered during regular business hours. If you have an urgent problem requiring attention after hours, please call the office phone and you will be forwarded to the answering service. ***In the event of a medical emergency*, *please go to the Emergency Room!*** **Prescription refills are not considered an emergency**.

Appointments . . .

We make every attempt to schedule patients at the earliest possible opening. Should you need to cancel or reschedule, please give us at least 24 hours notice so that we can move another patient into the open time slot. **Many of our patients have complex diagnostic problems, and although we try to stay on schedule, a patient's condition may require additional time--and that creates delays in our schedule**. We cannot accommodate walk-ins; patients are seen by appointment only.

Prescription refills . . .

A physician review of a patient's chart prior to refilling or amending a prescription is required. For this reason, we ask our patients to request their refills at least 72 hours in advance of the need. We ask that you contact your pharmacy with your request, and allow the pharmacist to contact our office. Please check with the pharmacy directs to see if your refill has been approved—and remember to allow 72 hours! If you called on Friday or a holiday, you may check with your pharmacy on the next business day after 4 pm. **No refill requests will be accepted after office hours or on weekends**.

Payment policy . . .

Payment is due and payable at the time of service unless:

1) You are insured with Medicare. The deductible and copay is due at the time of service.
2) You are insured with a managed care plan with which our office participates. The amount due at the time of service will depend of the specifics of your plan. Copayments and deductibles are due at the time of service.

Hospitals . . .

Dr. Chansolme has staff privileges at a number of hospitals in the metro area but works primarily at Integris Southwest Medical Center. Any admissions will be to Integris Southwest Medical Center. If your plan requires admission to a different hospital, please alert our staff so that we can accommodate this need.

Disability policies . . .

Disability policies are private policies owned by the patient. Forms will require a charge of **$30 to $50 per form** to be completed, and **without exception** the **money must be prepaid** at the time the form is left with our office. We require 10 days to complete the form. Patients may come by to retrieve their form, or they may provide our office with a stamped, self-addressed envelope and it will be forwarded as indicated.

Diagnostic tests, x-ray and lab results . . .

If Dr. Chansolme orders a test, results will usually be available within 10 working days. Because of the volume of testing we perform, it is not possible to telephone all patients with their results. However, if you would like to know the results of your tests, please call our office and we will be happy to assist with the information. If the test was ordered or performed by another physician, you should contact that office for your results. Even if we obtained preauthorization for the procedure, you will still need to contact the office that originally ordered or performed the test for results.

Signature ____________________ Date ____________________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, David H. Chansolme, M.D. and Nestor M. Quezada M.D. may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations**. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Chansolme and Dr. Quezada reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Name of Privacy Officer	David H. Chansolme, M.D., Inc. and Nestor M. Quezada M.D. Practice
Address	City, State, Zip

Telephone

With my consent, David H. Chansolme, M.D. and Nestor M. Quezada M.D. may call my home or another designated location and leave a message (on voice mail, answering machine or in person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, David H. Chansolme, M.D. and Nestor M. Quezada M.D. may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, David H. Chansolme, M.D. and Nestor M. Quezada M.D. may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that David H. Chansolme, M.D. and Nestor M. Quezada M.D. restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by David H. Chansolme, M.D. and Nestor M. Quezada M.D..

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, David H. Chansolme, M.D. and Nestor M. Quezada M.D. may decline to provide treatment to me.

Print Patient's Name	Signature of Patient **or Legal Guardian*	Date

Attention Privacy Officer:

If a patient wishes to limit how he or she is contacted by our practice or the release of information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.

©

NOTICE OF PRIVACY PRACTICES

Infectious Diseases Consultants of Oklahoma City
4221 S. Western Ave. Ste. 4010
Oklahoma City, OK 73109

Privacy Officer: Office Manager, 405-644-6464

Effective Date: 09/16/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOUCAN GET ACCESS TO YOUR ***PROTECTED HEALTH INFORMATION.***
Please review this notice carefully.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by the medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your right and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How this Medical Practice May Use or Disclose Your Protected Health Information

This medical practice collects health information about you and stores it in an electronic health record/personal health record on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

The following categories describe the different ways in which we may use and disclose you PHI (Protected Health Information)

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including but not limited to, our doctors and nurses- may use or disclose your PHI in order to treat you or assist others in your treatment. Additionally, we may disclose your PHI to others, such as your spouse, children or parents who may assist in your care when you are sick, injured or after you die.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualification of professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection

and compliance programs and business planning and management. We may also share your medical information without "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other care providers, health care clearinghouses or health plans that have a relationship with you , when they request this information to help them with their quality assessment and improvement activities, their patient-safety, activities, their protocol development and care-coordination activities, their training programs, their detection and compliance efforts. We may also share medical information about you with health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. Our practice may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

6. Marketing. Provided we do not receive any payment for making these communications, our practice may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or services provided by this practice and tell you which health plans this practice participates in. We may receive compensation which covers our cost of reminding you to take care of refilling your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

7. Sale of Health Information. Our practice will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we stop any future sales of your information to the extent that you revoke that authorization.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

9. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintain vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease or condition
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related to workplace injury or illness or medical surveillance

10. Health Oversight Activities. Our practice may, and are sometimes required by laws, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

11. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

12. Law Enforcement. Our practice may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. Our practice may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. Our practice may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Research. Our practice may disclose your protected health information to researcher's conduction research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

16. Public Safety. Our practice may, and are sometimes required by law, to disclose your health information to appropriate person in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized Government Factions. Our practice may disclose your protected health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Workers' Compensation. Our practice may disclose your protected health information as necessary to comply with workers' compensation laws.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your protected health information record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Protected Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Special Privacy Protections. You have the right to request that you receive your protected health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3.
4. Right to Inspect and Copy. You have the right to inspect and copy your protected health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in you requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance the cost of preparing and explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial

harm to patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

5. Right to Amend or Supplement. You have a right to request that we amend your protected health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is in accurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practices denial and how can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent of the disputed information.

6. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (release of information to family/friends) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official that providing this accounting would be reasonably likely to impede their activities.

7. Right to a Paper or Electronic Copy of this Notice. You have the right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously request its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Jorge Lozano, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hippa/complaints.pdf. You will not be penalized in any way for filing a complaint.

HEALTH HISTORY FORM

Confidential - subject to HIPAA regulations

Today's date:___/___/___

Patient name:____ Age:________ DOB:____/____/_____

Why are you visiting the physician today?____

____

____

History of Chronic Illness:

___ Diabetes
___ High blood pressure
___ HIV/AIDS
___ Anemia
___ Emphysema or COPD (lung disease)
___ Congestive heart failure
___ Heart Attacks
___ Hepatitis (type_____)
___ High Cholesterol
___ Chronic kidney disease
___ Chronic liver disease
___ Bleeding disorders
___ Cancer (type:________________________________)

Did you take or are you currently on chemotherapy?_Yes _ No If so, when was your last therapy?_____________

___ Multiple sclerosis
___ Vascular disease
___ Stroke
___ Thyroid disease
___ Tuberculosis
___ Headaches
___ Chemical dependency
___ Depression
___ Psychiatric disorder
___ Prostate problems
___ Deficient immune system
(type:__________________)

___ Rheumatoid Arthritis
___ Lupus
___ Paralysis
___ Other___________________
___ Other___________________
___ Other___________________
___ Other___________________
___ Other___________________
___ Other___________________
___ Other___________________
___ Other___________________
___ Other___________________

Have you ever been hospitalized?

Why?	When?	Where?

Have you ever had surgery?

Type of surgery:	When?	Where?

Do you have any medication allergies?

__ No known drug allergies

Medication:	Type of reaction:

Are you on any medications currently?

Medication:	Dosage:	Number of doses per day:

Do you use tobacco?

__Yes __No

__Cigarettes - # packs per day ______________

__Other tobacco product

__type ___________________________________

Do you drink alcohol?

__Yes __No

number of drinks per day________________

number of times per week you drink___________

Do you use any street drugs?

___ marijuana

___ cocaine

___ meth

___ other_____________________________

____

How often do you use drugs?

____

What is your profession?

____

____

Do you own any pets?

____

____

____

____

__ indoors or __ outdoors

Have you ever travelled outside the U.S.?

Where?	When?

Do you have any of the following symptoms?

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of consciousness
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Loss of balance
- ☐ Headaches
- ☐ Neck stiffness
- ☐ Loss of Sleep
- ☐ Weight loss
- ☐ Generalized numbness

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Productive sputum
- ☐ Coughing blood
- ☐ Sore throat
- ☐ Mouth ulcers
- ☐ Thrush

Cardiovascular

- ☐ Chest pain
- ☐ Poor circulation
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Rapid heart beat
- ☐ Swelling of legs/ankles
- ☐ Varicose veins
- ☐ Pacemaker
- ☐ Angioplasty
- ☐ Enlarged heart

Gastrointestinal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Excessive gas
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Excess fluid in belly
- ☐ Difficulty swallowing
- ☐ Ulcer disease
- ☐ Abdominal pain

Eyes, Ear, Nose, Throat

- ☐ Blurry vision
- ☐ Floaters
- ☐ Double vision
- ☐ Seasonal allergies
- ☐ Nasal stuffiness
- ☐ Sinus congestion
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Hoarseness
- ☐ Persistent cough
- ☐ Thyroid swelling
- ☐ Neck masses

Skin

- ☐ Boils
- ☐ Abscesses
- ☐ Spider bites
- ☐ Scars
- ☐ Non-healing wounds
- ☐ Easy bruising
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ New moles
- ☐ Lumps
- ☐ Open sores

Orthopedics

- ☐ Joint pain
  - ☐ legs/feet
  - ☐ arms/hands
  - ☐ back/neck
  - ☐ knees
- ☐ Numbness
  - ☐ legs/feet
  - ☐ arms/hands
  - ☐ back/neck
  - ☐ knees
- ☐ Weakness
  - ☐ legs/feet
  - ☐ arms/hands
  - ☐ back/neck
  - ☐ knees
- ☐ Fractures
- ☐ Joint replacement

Women only

- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Breast enlargement/reduction surgery
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Menstrual pain
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Have you had children?
- ☐ Have you had a mammogram?

Men only

- ☐ Penis discharge
- ☐ Lump in testicles
- ☐ Sore on penis
- ☐ Erection difficulties

Men and Women

Is there a history of:

- ☐ Chlamydia
- ☐ Clap
- ☐ Genital warts
- ☐ Herpes
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Genital ulcers
- ☐ Scabies or Crabs
- ☐ Trichomonas
- ☐ Yeast infections
- ☐ Other sexually transmitted disease __________

Family History

	Living	Deceased	Unknown	Medical Problems	Cause of Death	Age at Death
Mother						
Father						
Other						

Any other issues we need to know?