

PATIENT FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ LAST NAME \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex assigned at birth:  Male  Female

Gender Identity:  Male  Female  Transgender Male / Female to Male  
 Transgender Female / Male to Female  Other  Choose not to disclose

Sexual Orientation:  Lesbian or Gay  Straight (not lesbian/gay)  Bisexual  
 Something else  Don't know  Choose not to disclose

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Mailing Address (if different): \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

**Appointment reminders / Confirmations / Special Notices / Sharing Information**

Email and text messaging allows us to exchange information efficiently. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly during transmission. If you would like us to send email and/or text messages that contains your health information, please provide the following information to authorize CCHD to communicate with you and other health care providers for your medical care and treatment.

\*\* Complete the following only if email / text correspondence is being authorized:

Email to send me information: \_\_\_\_\_

Phone Number to send me texts: \_\_\_\_\_

\*If you prefer not to authorize the use of email / text messaging we will continue to use U.S. Mail or telephone to communicate with you.

**YOUR PRIMARY CARE DOCTOR IS:** \_\_\_\_\_  Dr. Royeen  Dr. Curry  Emily Eichelberger NP  
**YOUR DENTIST IS:** \_\_\_\_\_  Dr. Watson  Dr. Johnson  Dr. Buskirk  
**PREFERRED PHARMACY IS:** \_\_\_\_\_ @ \_\_\_\_\_

**Ethnicity**  Not Hispanic / Not Latino  
 Hispanic / Latino  
 Unknown / Not Reported

**Race**  American Indian/Alaska Native  Asian  
 Black/African American  White  
 More than one race  Native Hawaiian  
 Other Pacific Islander  Declined

**Marital Status:**  Single  Married  
 Legally Separated  Divorced  Widowed

**Are you a: Student?**  No  Yes **Veteran?**  No  Yes **Migrant Worker?**  No  Yes

**Housing:**  Own  Rent  Income Based / Public Housing  Living with Friends / Family  
 Homeless

**What is the approximate annual household income?** \_\_\_\_\_ **Family Size** \_\_\_\_\_  Refused to Report

**Does patient need an interpreter?**  No  Yes -Spanish / French / Sign Language

**If patient is under the age of 18 does the parent/guardian need an interpreter?**  
 No  Yes -Spanish / French / Sign Language

**Does patient have a Power of Attorney For Healthcare/ Advance Directive / Do-Not-Resuscitate order / Court Ordered Guardian?**  No  Yes \*If yes please provide us with a copy.

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

NAME: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION** \*Person to be billed if other than patient

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_  
(Address) (City) (State) (Zip)

Phone Number: \_\_\_\_\_

All clients have the right to treatment by the Cass County Health Department (CCHD) without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

The above information is true and correct to my knowledge.

I accept full responsibility for my/my child's care and treatment and release the CCHD and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment.

I authorize the CCHD to provide service to me and to release necessary information to bill, process and receive payment of Medical / Dental Benefits (private insurance, Medicare, or Medicaid, etc.), for Medical and Professional Services Rendered.

**PATIENT RIGHTS AND RESPONSIBILITIES:** I understand it is my responsibility to read and follow the information contained in this notice. All clients have the right to treatment by CCHD without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

**NOTICE OF PRIVACY PRACTICES:** My signature below also indicates that I have been offered a copy of CCHD's "Notice of Privacy Practices." I understand it is my responsibility to ask any questions I may have.

Client (or Parent)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

How did you hear about us?  Newspaper  Friend/Family  Billboard  Radio

Other \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES**

*Thank you for choosing Cass County Health / Dental / Behavioral Health Clinic for your medical / dental and behavioral health care. Our staff values your time and we hope you will, in turn, value ours. In order to serve you better we have the following office policies for you to review and sign. Agreeing to these policies will enable us to provide better care to you in a timely and efficient manner.*

**PAYMENT**

- All payments / copays for services performed are due at the time of service
- Eligibility for services under Illinois Medicaid will be determined prior to the start of each visit.
- You must bring your current insurance card for each appointment. If eligibility cannot be verified, you will be required to pay for the service.
- Any services not covered by Medicaid, Medicare and/or medical / dental insurance will be your responsibility to pay.
- A patient with a past due balance will be required to consult with our billing office to set up a payment plan to pay off the past due amount.
- I understand if my account is referred to a Collection Agency I will be responsible for Collection costs incurred.

**SLIDING FEE SCHEDULE**

- We offer a sliding fee plan to allow patients who have provided proof of income to receive services at an affordable fee. Your fee is determined by the income and size of your family.
- The sliding fee schedule is based on the United States Department of Health and Human Services Guidelines.

**APPOINTMENTS**

- It is your responsibility to remember your appointment. In order for us to provide a courtesy call, a current contact phone number is required. It is your responsibility to inform us of any changes.
- Staff will call to confirm appointments. You must answer, or call us back within 24 hours, or your appointment will be cancelled.
- If your phone number is disconnected or not updated or your voicemail is not working, your appointment may be filled with another patient.
- New patients will be asked to show up to their appointment 30 minutes prior to the start of their appointment to complete new patient paperwork.

**TREATMENT OF MINORS**

All minors must be accompanied by a legal guardian or a legal guardian must give written permission for another individual to accompany them by completing the required Proxy Form. Depending on the treatment to be provided a legal guardian may be required to be on site to give informed consent except in cases where minors may seek care as allowed by Illinois state law.

**PATIENT CENTERED MEDICAL HOME**

A patient centered medical home is a system of care in which a team of health professionals work together to provide all of your health care needs. We use technology such as electronic medical records to communicate and coordinate your care and provide the best possible outcomes for you. You, the patient, are the most important part of the patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need!

**I understand and agree to the above written policies.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

### Consent to Release Information to Designated Family Member or Caregiver

The names listed below are allowed to have information released to them from Cass County Health Department with the undersigned consent.

Name	Relationship	Phone
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Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
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Signature \_\_\_\_\_ Date \_\_\_\_\_

\*This consent may be revoked at any time upon written request.

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

School Attending:

School Grade: \_\_\_\_\_

- A/C Elementary       A/C Jr. High       A/C HS       Beardstown HS
- Beardstown Grand       Beardstown Gard       Beardstown Jr. High       BCA
- Virginia Elementary       Virginia Jr. High       Virginia HS       Alternative School
- Pre-school or Other

- \*Does this child live in Cass County?  No  Yes
- \*Does this child attend a Cass County School?  No  Yes
- \*Is this child a brother or sister of a child attending a school in Cass County?  No  Yes

Mother's Maiden Name: \_\_\_\_\_

I, as the authorized representative/ parent/ guardian of this patient, authorize the following person(s) to transport, accompany, authorize, and consent to any x-ray, exam, medical, dental, psychiatric, or psychological diagnosis or treatment to be rendered by CCHC/CCDC staff. All providers may discuss patient's care with those listed below.

Initials	Proxy Name	Relationship to Patient	Phone#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_ This patient (if 12 years or older) may present and receive diagnosis, treatment, and instruction  
 \_\_\_\_\_ without additional supervision  
 \_\_\_\_\_ Myself ONLY

Initials

105 ILCS 129: <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2935&ChapterID=17>

The School Health Center Act -Requires the SHC to list the available services, giving parent the option to opt out of certain services. Minor Consent laws still apply.

The Cass County School Health Center (CCSHC) consists of a seamless partnership of trusted local agencies dedicated to the health and well-being of your child. The partnership includes; A Physician, Nurse Practitioner or Physician Assistant, Dentist, Dental Hygienist, Nurse and Mental Health Counselor are available, based on schedules, to provide primary health care, dental care, psychosocial services and nutritional consultation to ALL students enrolled.

Available services may include, but are not limited to:

1. Physical examination, health assessments, screening for health problems
2. Diagnosis and treatment of acute illness and injury
3. Diagnosis and management of chronic illness
4. Health education and promotion. Outreach health promotion /prevention workshops will be offered
5. Immunizations
6. Wellness promotion including smoking cessation, nutrition, weight management
7. Reproductive health care including: gynecological examinations with PAP smears, STD education, testing, and treatment, HIV/AIDS education, counseling / testing, and contraceptive services
8. Laboratory tests including throat cultures, complete blood counts, mono spots etc.
9. Mental Health counseling services
10. Dental examination and treatment
11. Referrals to other linkage agencies for services not provided at Cass County School Health Center

410 ILCS 210/1, et seq. <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1539&ChapterID=35>

PARENTAL/GUARDIAN CONSENT

The aforementioned child has my consent to receive services offered at the Cass County School Health Center (CCSHC) located in Cass County Illinois, by its contracted providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care services. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing the Health Center to provide services to my child in his/her best interest.

I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services.

I consent to the release of relevant health information and medical records in connection with treatments to the School Health Center and its collaborating partners to facilitate my child's health needs. I further authorize the School Health Center to release information regarding my child's treatment to third party payors or others for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

I understand that if my child is 12 or older they can receive mental health/substance abuse services at the CCSHC without my consent. Per 405 ILCS 5/3-5A-105(a), they may receive up to eight 90-minute sessions for mental health services. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

This authorization will remain in effect unless specifically revoked in writing.

⇐ \_\_\_\_\_ AND ⇐ \_\_\_\_\_  
 Representative / Parent Guardian Signature      Date      Patient Signature (age 12 or older)      Date

Office Use Only:  Certification of Unaccompanied Minor Status

Cass County Health Department Authorization  
 Departamento de Salud del Condado de Cass Autorización  
 Cass County Health Department Authorization

Patient's Name - PLEASE PRINT El Nombre del Paciente Nom du Patient -- LETTRE MOULÉES	Patient's Date of Birth Fecha de Nacimiento del Paciente Date de naissance du patient	Patient's Street Address La Dirección del Pacient Adresse du Patient	City Ville	State État	Zip Code Code postal
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➤ I hereby authorize the use or disclosure of protected health information about me as described below.  
 Yo por la presente autorizo el uso y revelación de la información protegida de salud acerca de mí describieron como abajo.  
 Par la présente, j'autorise l'utilisation ou divulgation d'informations protégées sur ma santé tel que décrit ci-dessous.

➤ I authorize Cass County Health Department to disclose: (check all that apply)  
 Yo doy autorización al Departamento de Salud del Condado de Cass para revelar información acerca de los siguientes:  
 (cheque todos que son aplicables)

J'autorise le Cass County Health Department à divulguer: (cochez tout ce qui s'applique)

- ✓ Physical Exam; Examen Físico; Examen physique
- ✓ Vision Screen; Exam Vista; Test de la vue
- ✓ Lead Screen; Examen del Plomo; Test de plomb
- ✓ Hemoglobin /Hematocrit test; Cheque del hierro en su sangre; Test d'hémoglobine /hématocrite
- ✓ Appt Date & Time; Fecha/Hora de las citas; Date de rendez-vous & Heure
- ✓ TB Skin Test; Prueba Tuberculosis; Test sur la tuberculose
- ✓ Hearing Screen; Examen del Oído; Test d'audition
- ✓ Immunization Record; Vacunas; Carnet de vaccination
- ✓ Other; Otros; Autre: \_\_\_\_\_

➤ TO: (check one); Información puede ser revelada a: (cheque uno); A: (check one)  A-C Central School District; Distrito de la Escuela de A-C Central  Beardstown Christian Academy; Escuela de Beardstown Christian Academy  Beardstown School District; Distrito de la Escuela de Beardstown  Trinity Lutheran School; Escuela de Trinity Lutheran  Virginia School District; Distrito de la Escuela de Virginia  Other; Otros; Autre \_\_\_\_\_

➤ The information may be used or disclosed for each of the following purposes: For the maintenance of school records / Verification of excused absences

Esta información puede usarse y ser revelada para cada uno de los propósitos siguientes: Para conservar los registros de escuela / Para comprobar la ausencia dispensada de la escuela

L'information peut être utilisée ou divulguée dans le but suivant: Pour la mise à jour des dossiers scolaires / Pour la verification d'absences

➤ I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

Entiendo que la información usada o revelada puede ser revelado otra vez por la persona(s) o la clase de persona(s) lo recebiendo y que no protegido por las regulaciones federales de la confidencialidad.

Je comprends que l'information utilisée ou divulguée peut être sujet à une re-divulgation par la (les) personne(s) ou classe de(s) personne(s) recevant ces informations et ne sera plus protégé par les régulations fédérales privées.

➤ I understand that I may revoke this authorization by notifying the Privacy Officer in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Cass County Health Department in reliance on it before I revoked it.

Entiendo que puedo revocar esta autorización notificando al Oficial de la Confidencialidad al escribirle de mi deseo para revocarlo. Sin embargo, yo entiendo que si revoco esta autorización, no tendrá ningún afecto en acciones tomadas por el Departamento de Salud antes de yo lo revoqué

Je comprends que je peux révoquer cette autorisation en avisant l'Officier sur la vie privée par écrit. Toutefois, Je comprends que si je révoque cette autorisation, il n'y aura aucune conséquence sur les actions prises par le Cass County Health Department en dépendance avant révocation.

➤ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Entiendo que puedo negarme a firmar esta autorización y que al negarme no afectará mi habilidad de obtener el tratamiento, ni el pago, ni mi elegibilidad para beneficios.

Je comprends que je peux refuser de signer cette autorisation et que mon refus de signer n'affectera pas mon ability d'être traité ou paiement ou mon éligibilité pour avantages.

➤ I understand this authorization will expire on (check and complete one):  \_\_\_\_\_, 20\_\_\_\_, or ✓ Upon withdrawal from school or high school graduation.

Entiendo que la autorización expirará en (cheque y completará uno):  \_\_\_\_\_, 20\_\_\_\_, or ✓ En el acontecimiento de la graduación de la preparatoria, la terminación del nivel más alto del grado ofreció (para esos no ofreciendo graduación de la preparatoria), o dejan de asistir en la escuela.

Je comprends que cette autorisation expirera (cochez et complétez):  \_\_\_\_\_, 20\_\_\_\_, ou ✓ -Lors du retrait de l'étudiant (enfant) de l'école ou lors de la graduation.

This form must be fully completed before signing/Esta forma debe ser completada antes de firmar/Ce formulaire doit être complété complètement avant d'être signé

Signature of Patient or Legal Guardian  
 La Firma del Paciente o Representante Personal  
 Signature du Patient ou Gardien legal

Date of Signature  
 La Fecha de la Firma  
 Date de la signature

PLEASE PRINT Name of Person Signing this Authorization If not Patient  
 Nombre del Representante Personal (SI es aplicable)  
 Le nom de la personne qui signe cette autorisation si ce n'est pas le patient

## HEALTH HISTORY QUESTIONNAIRE

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

<b>NAME (Last, First, M.I.):</b>	<input type="checkbox"/> M	<input type="checkbox"/> F	<b>DOB:</b>			
<b>MARITAL STATUS:</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Previous Or Referring Doctor:</b>				<b>Date Of Last Physical Exam:</b>		

<b>PERSONAL HEALTH HISTORY</b>						
CHILDHOOD ILLNESSES:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
IMMUNIZATIONS AND DATES:	<input type="checkbox"/> Influenza	<input type="checkbox"/> Td	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis B		
HEALTH SCREENINGS	<input type="checkbox"/> Colonoscopy When/Where:			<input type="checkbox"/> Chest XRay When/Where:		
	<input type="checkbox"/> Rectal Exam/Blood When/Where:			<input type="checkbox"/> EKG When/Where:		

<b>LIST MEDICAL PROBLEMS OTHER DOCTORS HAVE DIAGNOSED</b>											
Diabetes	Yes	No	Arthritis / Gout	Yes	No	Epilepsy	Yes	No	Bleeding disorder	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No	Hepatitis	Yes	No	Cataracts	Yes	No
Cancer	Yes	No	Heart Problems	Yes	No	Blood Clots	Yes	No	Thyroid Problems	Yes	No
Stroke	Yes	No	Antibiotic Resistant Infections	Yes	No	Lupus	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Sexually Transmitted Disease	Yes	No	Glaucoma	Yes	No	High Cholesterol	Yes	No
COPD	Yes	No	Congestive Heart Failure	Yes	No	Depression	Yes	No			
Other _____											

<b>SURGERIES &amp; OTHER HOSPITALIZATIONS</b>		
Year	List Surgery	Hospital

<b>LIST YOUR PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS AND INHALERS</b>					
Drug Name	Strength	How often?	Drug Name?	Strength	How often?

<b>ALLERGIES (MEDICATIONS, FOOD, SEASONAL OR ENVIRONMENTAL)</b>					
Allergy to what?	Reaction?	Allergy to what?	Reaction?	Allergy to what?	Reaction?

<b>HEALTH HABITS AND PERSONAL SAFETY</b>					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
<b>Alcohol</b>	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		How many drinks per week?		
<b>Caffeine</b>	Do you use caffeine?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind? <input type="checkbox"/> Chocolate <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda <input type="checkbox"/> Energy Drink <input type="checkbox"/> Tablet				
<b>Tobacco</b>	Do you use tobacco?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
<b>Drugs</b>	Do you currently or have you ever used recreational or street drugs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Type/Frequency _____				
<b>Tattoos</b>	Have you ever given yourself street drugs with a needle?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any tattoos?				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diet</b>	Diet <input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Low Salt / Low Sodium <input type="checkbox"/> Low Fat <input type="checkbox"/> Other _____				
<b>Exercise</b>	Exercise -Describe _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME (Last, First, M.I.): \_\_\_\_\_ DOB: \_\_\_\_\_

**CONSTITUTIONAL SYMPTOMS**

Poor health lately	Yes	No
Recent weight change	Yes	No
Fatigue/ Tiredness	Yes	No

**EYES**

Eye Disease / Injury	Yes	No
Glasses / Contacts	Yes	No
Blurring	Yes	No
Double Vision	Yes	No

**EAR / NOSE / MOUTH / THROAT**

Hearing loss / Ringing in ears	Yes	No
Ear ache or drainage	Yes	No
Chronic Sinus Problems	Yes	No
Nosebleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath / bad taste	Yes	No
Sore Throat	Yes	No
Swollen glands in neck	Yes	No

**CARDIOVASCULAR**

Chest Pain / Angina	Yes	No
Palpitations (Irregular heartbeat)	Yes	No
Shortness of Breath	Yes	No
Swelling of Feet	Yes	No

**RESPIRATORY**

Chronic / Frequent Cough	Yes	No
Coughing up blood	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No

**GASTROINTESTINAL**

Loss of appetite	Yes	No
Change in bowel movements (poop)	Yes	No
Nausea or Vomiting	Yes	No
Frequent Diarrhea	Yes	No
Painful bowel movements / Constipation	Yes	No
Rectal / Butt Bleeding	Yes	No
Abdominal Pain / Heartburn	Yes	No

**GENITOURINARY**

Frequent Urination (pee)	Yes	No
Burning / Painful Urination (peeing)	Yes	No
Blood in urine (pee)	Yes	No
Incontinence (Wetting underpants) / Dribbling	Yes	No
Kidney Stones	Yes	No
Sexual Problems	Yes	No

**MUSCULOSKELETAL**

Joint Pain	Yes	No
Joint stiffness / swelling	Yes	No
Weakness of muscles	Yes	No
Muscle Pain / Cramps	Yes	No
Back Pain	Yes	No
Cold hands or fingers / feet or toes	Yes	No

**INTEGUMENTARY**

Rash or Itching	Yes	No
Change in skin color	Yes	No
Change in hair or fingernails	Yes	No
Varicose veins	Yes	No
Excessive moles	Yes	No
Excessive exposure to sun	Yes	No
Lesions or Sores	Yes	No

**NEUROLOGICAL**

Frequent headaches	Yes	No
Lightheaded / Dizzy	Yes	No
Convulsions / Seizures	Yes	No
Numbness / Tingling	Yes	No
Tremors / Shakes	Yes	No
Paralysis	Yes	No
Head Injury	Yes	No

**PSYCHIATRIC**

Memory Loss / Confusion	Yes	No
Nervousness / Anxiety	Yes	No
Sadness	Yes	No
Insomnia / Unable to sleep	Yes	No

**ENDOCRINE**

Gland or Hormone Problems	Yes	No
Skin becoming drier	Yes	No
Excessive thirst or urination	Yes	No
Get too cold / get too hot (hot flashes, etc)	Yes	No

**HEMATOLOGIC / LYMPHATIC**

Slow to heal after cuts / injury	Yes	No
Bleeding / Bruising easily	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past blood transfusions	Yes	No
Enlarged glands	Yes	No

**OTHER**




NAME (Last, First, M.I.): \_\_\_\_\_

DOB: \_\_\_\_\_

**FAMILY HISTORY**

	Health Problems	Age	Deceased		Cause of Death		Health Problems	Age	Deceased		Cause of Death
			Yes	No					Yes	No	
Father		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Mother		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Children		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandmother Maternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandfather Maternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandmother Paternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	
Siblings		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No		Grandfather Paternal		<input type="checkbox"/> M <input type="checkbox"/> F	Yes	No	

**MEN ONLY**

Do you usually get up to urinate during the night? If yes, # of times _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sexually active? If yes with Male/Female/Both?- Please circle	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had more than one sexual partner in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**WOMEN ONLY**

Age at onset of menstruation: _____ Date of last menstruation: _____ Period every _____ days		
Last Pap Smear _____ Where? _____ Last mammogram _____ Last Bone Density screening _____		
Number of pregnancies _____ Number of live births _____ Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vaginal Discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sexually active? If yes with Male/Female/Both?- Please circle	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had more than one sexual partner in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No