Colorado Complete Health *for* Women

PATIENT HISTORY QUESTIONNAIRE

Patient Name:_____ Age:_____ Date:_____

Date of Birth:_____Primary care Provider:_____

Pharmacy Name:_____ Pharmacy cross roads:_____

Reason for visit: _____

Have you ever had the following and if so, please include date of diagnosis: (Circle No or Yes)

Anemia	NO YES	Back Trouble	NO YES	High Blood Pressure	NO YES
Blood Transfusion	NO YES	Migraine Headaches	NO YES	Tuberculosis	NO YES
Chickenpox	NO YES	Asthma	NO YES	Cancer	NO YES
Diabetes	NO YES	Bleeding Tendency	NO YES	If yes, what kind _____	
Pneumonia	NO YES	Hernia	NO YES	Hepatitis	NO YES
Heart Problem	NO YES	Kidney Disease	NO YES	Thyroid Disease	NO YES
Ulcer	NO YES	Arthritis or Lupus	NO YES	Inherited Diseases	NO YES
Seizure Disorder	NO YES				

Please list your past medical problems	year diagnosed

Previous Hospitalizations/ Surgeries/ Serious Illnesses	when	complications

Medication (including nonprescription like supplements, herbs, vitamins, etc.)

Name of medication	Dosage	how often a day

Vaccinations:

(Please circle and list year)

TDaP(Tentanus) NO YES_____

Influenza..... NO YES _____

Gardasil..... NO YES _____

Pneumonia..... NO YES _____

Drug allergies:_____ **O**ther allergies: _____

Social History

Occupation: _____

Marital status Single: _____ Married: _____ Separated: _____ Divorced:_____ Widowed_____

Use of alcohol Never: _____ Rarely: _____ Occasional: _____ Daily: _____

Use of Tobacco Never: _____ Previously, but quit:_____Current packs/day: _____

Use of recreational drugs Never: _____ Type/frequency: _____

Date: _____ **Dr:**_____	**Review Date:**_____ **Dr.** _____	**Review Date:** _____ **Dr:**_____	**Review Date:**_____ **Dr:**_____

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PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

Obstetrical History

Please list the number of Total Pregnancies: _____

Premature births_____ Miscarriages_____Abortions_____Living Children _____

Date	Weeks Preg.	Type of Delivery (include ectopic, miscarriage, abortion, vaginal ,cesarean section)	Birthweight (lb., oz.)	Complications

Menstrual History

Age when periods started_____How many days from start of one period to start of the next (day 1 to 1) _____
Number of day's menstrual flow lasts____ Flow is: Light_____Medium_____Heavy_____
Number of (pads_____tampons_____) used on heaviest day_____
Periods are: Regular_____Irregular_____absent _____
Cramping: None_____Mild_____severe_____Medication taken for cramping: _____
Spotting between periods: None_____Occasionally_____Always_____
Bleeding with or after intercourse?_____Date of last normal menstrual period: _____
If post-menopause, age at time of menopause _____

Are you currently sexually active? NO YES
Problems with type of birth control used: _____
What type of birth control are you currently using? _____

Gynecologic History

Have you ever had any of the following?

Pelvic infection	NO YES	Vaginal infection	NO YES
Venereal infection ("VD") (Gonorrhea, Chlamydia. HPV, Syphilis, Herpes)	NO YES	(Yeast infection, Bacterial vaginosi s, Trichomoniasis)	
Genital warts	NO YES	Abnormal Pap smear	NO YES
Cervical surgery (freezing, laser, leep)	NO YES	Hysterectomy	NO YES
Ovarian cyst(s)	NO YES	Ovary (ies) removed	NO YES
Ectopic (tubal) pregnancy	NO YES	Bladder or rectal repair	NO YES
Problem with excess hair	NO YES	Breast lump or biopsy	NO YES
Loss of urine w/ coughing or straining	NO YES	Hormone replacement therapy	NO YES
Symptoms of hot flash, night sweats, vaginal dryness, or insomnia			NO YES

Approximate date of last Papsmear _____
Approximate date of last colonoscopy _____
Approximate date of last pelvic exam _____
Approximate date of last bone density test _____
Approximate date of last mammogram _____

Review Date: _____ **Dr:** _____	**Review Date:** _____ **Dr.** _____	**Review Date:** _____ **Dr.** _____	**Review Date:** _____ **Dr:** _____

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PATIENT HISTORY QUESTIONNAIRE

PatientName: _____ Date: _____

FAMILY HISTORY

Has any family member ever had breast, cervical, ovarian, uterine, or colon cancer? .....NO YES
If yes, who and what type_____

Has any family member had Heart Disease, Diabetes, Thyroid problems, or Osteoporosis? ..... NO YES
If yes, who and what type? _____

Review of systems: (**Please indicate if you have any of the following symptoms currently)**

☐ **Constitutional Symptoms**

Good general health lately NO YES
Recent weight change NO YES
Fever NO YES
Fatigue NO YES

☐**Eyes**

Eye disease or injury NO YES
Wear glasses/contacts NO YES
NO YES
Blurred or double vision NO YES

☐**Ears/Nose/Mouth/Throat**

Hearing loss or ringing NO YES
Earaches or drainage NO YES
Chronic sinus NO YES
Nose bleeds NO YES
Mouth sores NO YES
Bleeding gums NO YES
Bad breath or bad taste NO YES
Sore throat or voice change NO YES
Swollen glands in neck NO YES

☐ **Cardiovascular**

Heart trouble NO YES
Chest pain or Angina NO YES
Palpitations NO YES
Shortness of breath w/ walking
Or laying down NO YES
Swelling feet, hands, ankles NO YES

☐ **Gastrointestinal**

Loss of appetite NO YES
Change in bowel movements NO YES
Nausea or vomiting NO YES
Diarrhea NO YES
Pain in bowel movements NO YES
Constipation NO YES
Rectal bleeding/blood in stool NO YES
Gallbladder disorder NO YES

☐ **Genitourinary**

Frequent urination NO YES
Burning/painful urination NO YES
Blood in urine NO YES
Incontinence or dribbling NO YES
Kidney stones NO YES

☐ **Musculoskeletal**

Joint Pain NO YES
Joint stiffness/swelling NO YES
Weakness of muscles/joints NO YES
Muscle pain or cramps NO YES
Back pain NO YES
Cold extremities NO YES
Difficulty in walking NO YES

☐ **Integumentary (skin/breast)**

Rash or itching NO YES
Change in skin color NO YES
Change in hair or nails NO YES
Varicose veins NO YES
Breast pain NO YES
Breast discharge NO YES

☐ **Neurological**

Frequent/Recurring headaches NO YES
Lightheaded or dizzy NO YES
Convulsions or seizures NO YES
Numbness or Tingling NO YES
Tremors NO YES
Head injury NO YES

☐ **Respiratory**

Persistent cough over 3 weeks NO YES
Spitting up blood NO YES
shortness of breath NO YES
Wheezing NO YES

☐ **Psychiatric**

Memory loss or confusion NO YES
Nervousness NO YES
Depression NO YES
Insomnia NO YES

☐ **Endocrine**

Glandular or hormone problem NO YES
NO YES Excessive thirst or urination
Heat or cold intolerance NO YES
Skin becoming drier NO YES
Loss of height NO YES

☐ **Hematologic/Lymphatic**

Slow to heal after cuts NO YES
Bleeding/bruising NO YES
Anemia NO YES
Past transfusion NO YES
Enlarged glands NO YES

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
Penicillin NO YES
Other antibiotics NO YES
Morphine, Demerol, or other narcotics NO YES
Novocain/anesthetics NO YES
Aspirin or other pain med NO YES
Tetanus antitoxin NO YES
Iodine NO YES
IV contrast NO YES
Other drugs/medications NO YES
_____
_____
_____

Review Date:_____ **Dr:**_____	**Review Date:**_____ **Dr.** _____	**Review Date:**_____ **Dr.** _____	**Review Date:**_____ **Dr:** _____

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Patient Name: _____ Date: _____

Other History

We want to be available to assist our patient with problems or questions about sexuality, abuse, and domestic violence. The information you provide may be related to certain medical conditions as well. We encourage all of our patients to feel free to discuss such issues. This, as with all medical information, is treated with strict confidence. Please answer each question only if you feel comfortable doing so.

Intercourse is painful……NO YES
My sexual interest is less than I/my partner would like……NO YES
I would like a referral for sexual counseling……NO YES
I am presently or in the past involved in an abusive/violent relationship……NO YES

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.

_____ _____

Signature of patient, parent, or guardian **Date**

Review Date: _____ **Dr:**_____	**Review Date:**_____ **Dr.** _____	**Review Date:**_____ **Dr.** _____	**Review Date:**_____ **Dr:** _____

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____ Race _____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

How Can We Reach You?

NAME (PLEASE PRINT) _____
HOME PHONE NUMBER _____
WORK PHONE NUMBER _____
CELLULAR WORK NUMBER _____

HealthOne Clinic Services
PHONE MESSAGE CONSENT

In effort to protect your privacy we have developed a policy on leaving medical care messages.

- We will not leave a message with anyone except the patient or legal guardian.
- We will NOT leave any confidential information on an answering service.
- We will NOT leave any message on a voicemail.

UNLESS
WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I,_____give HealthOne my permission to speak with and or leave phone messages regarding my medical care and or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My HOME voice mail #:_____Initials:_____

My CELL voice mail #:_____Initials: _____

My OFFICE/WORK voice mail #:_____Initials: _____

My spouse/guardian #:_____ Initials: _____

If other name: _____

Signature:_____Date: _____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Colorado Complete Health *for* Women

Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself on your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

About Health Insurance:

Your insurance policy is a contract with between you and your insurance company. As a courtesy, we will file your insurance claim for you. It is your responsibility to provide accurate and timely insurance information.

About Participating Health Plans:

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

For all service rendered to minor patients we will look to the adult accompanying the patient and parent or guardian with custody of payment.

It is your responsibility to verify that this office participates with your insurance. If we do not participate with your insurance, you will be responsible for all charges out of pocket.

By signing below, I acknowledge that I have read and understood the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to patient