Main Street Medical
Caring for the whole family

MINDEN Physician Practices

PATIENT REGISTRATION FORM

Patient Legal Name: _____ Marital Status: _____

Birthdate: _____ Social Security #: _____-_____-_____ May we text you? □ Yes □ No

Street or Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address (Required for portal access) _____

May we email you educational information? □ Yes □ No

Occupation: _____ Employer: _____ Employer Phone #: _____

Race: _____ Ethnicity: _____ Language (if other than English): _____

Pharmacy: _____ Pharmacy City: _____

Referred by: □ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □ Yellow Pages □ Other: _____

Family Doctor Name: _____ Family Doctor Phone #: _____

Date of last visit with family doctor: _____

RESPONSIBLE PARTY INFORMATION

Are you responsible for the bill? □ Yes □ No □ Check here if person responsible for bill is same as patient

If not: Name of Responsible Person: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Employer: _____

Insurance Policyholder Name: _____ Birthdate _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone Number: _____

Next of Kin: _____ Relationship: _____ Phone Number: _____

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

Patient|Guardian Signature: _____ Date|Time:_____

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PEDIATRIC MEDICAL HISTORY FORM

Patient Name: _____

DOB: _____/_____/_____

Parent/Guardian Signature: _____

Date: _____/_____/_____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medications, Vitamins, home remedies, birth control, herbs etc.*

Medication Name	**Dose**	**Frequency**

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

PERSONAL MEDICAL HISTORY: *Please indicate whether the patient has had any of the following medical problems.*

- ☐ Asthma
- ☐ Anemia
- ☐ Pneumonia
- ☐ Diarrhea
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Ear Infections
- ☐ Convulsions/Epilepsy
- ☐ Constipation
- ☐ Rheumatic Fever
- ☐ Vision Problems
- ☐ Hay Fever

Other:_____

_____

_____

HOSPITALIZATONS: *Please list all prior hospitalizations and dates.*

Reason	**Date**

IMMUNIZATIONS: *Please list immunizations that the patient has received at other health care facilities and include your best estimate of the month and year of each immunization.*

Hepatitis A: _____ Measles: _____ Mumps: _____ Rubella: _____ MMR: _____

Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Other: _____

COMMUNICABLE DISEASES:

Has the patient ever had any of the following communicable disease(s)?

☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

PREGNANCY & BIRTH:

Is the patient yours by: □Birth □Adoption □Stepchild □Other: _____

Were there any medical problems during pregnancy? □ Yes □ No If yes, please explain: _____

Were there any problems during labor and delivery? □ Yes □ No If yes, please explain: _____

Were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc. after the patient's birth? □ Yes □ No

If yes, please explain: _____

Where was the patient born? _____ Method of Delivery: □Vaginal □ Caesarean

Birth Weight/Length: ___lbs. ___oz. ___inches Was your child born prematurely? □ Yes □ No If yes how early: _____

For Male Patients Only: Is your child circumcised? □ Yes □ No

SLEEP:

How many hours a night does the patient sleep? _____ How many naps does the patient take per day and length of naps? _____

Does the patient have any sleep problems? □ Yes □ No If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding when the patient was a newborn: □Breastfed □Formula. If breastfed, for how long? _____

Has the patient had any feeding/dietary problems or restrictions? □ Yes □ No If yes, please explain: _____

_____

Milk intake now: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ other, please specify: _____, # of ounces per day _____

Has the patient seen a dentist? □ Yes □ No If yes, date of last visit _____. What is the water source at the house? □ City □ Well

DEVELOPMENT:

At what age did the patient: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Train (Daytime) _____

Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themselves, or feeding themselves? □ Yes □ No If yes, please explain: _____

Are there any area of concerns about language or speech development? □ Yes □ No If yes, please explain: _____

When the patient is in the car, do they use? □ Infant Seat □ Booster Seat □ Seatbelt Only

Does the patient wear a helmet while riding a bike? □ Yes □ No

Do you have concerns about the patient's behavior at home or in groups with other children? □ Yes □ No

If yes, please explain: _____

For Female Patients Only: Age at first menstrual period _____

SOCIAL HISTORY:

Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced. If divorced, for how long? _____

Mother's Employer: _____ Mother's Occupation: _____

Father's Employer: _____ Father's Occupation: _____

Do any household members smoke? □ Yes □ No

Is violence in the home a concern? □ Yes □ No

Are there guns in the home? □ Yes □ No

Would you like to speak with the physician regarding the patient's: □ Alcohol Use □ Tobacco Use □ Sexual Activity □ Aggressive Behavior

How many hours per day does the patient spend with the following: ___Watching TV ___On the Computer/iPad ___Playing Video Games

Do you have any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? □ Yes □ No

Do you have smoke detectors in your home? □ Yes □ No

Who lives at home with the patient?

Name	Age	Relationship	Highest Level of Education

SCHOOL HISTORY:

Did/Does the patient attend school/preschool? □ Yes □ No
Current grade in school? _____
Do you have concerns with how the patient is doing in school? □ Yes □ No
Any concerns about relationships with teachers or other students? □ Yes □ No
If more than 4 years old: does your child have a best friend? □ Yes □ No
Does your child play any sports? □ Yes □ No
How many times a week? _____ How long (minutes) _____

FAMILY HISTORY: *Please indicate with a check (√) who in the patient's family has had the following conditions. In the first column, please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	**Asthma**	**Diabetes**	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Heart Attack**	**Cancer (Type)**	**Colon Polyps**	**Depression**	**Other**
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

REVIEW OF SYSTEMS: *Please indicate with a check* (√) *any current problems your child has on the list below.*

CONSTITUTIONAL

- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss
- ☐ Fatigue/weakness
- ☐ Excessive thirst or urination

CARDIOVASCULAR

- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Palpitations

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

NEUROLOGICAL

- ☐ Headaches
- ☐ Numbness
- ☐ Dizziness/light-headedness
- ☐ Memory loss
- ☐ Loss of coordination

EYES

- ☐ Change in vision
- ☐ Nearsighted
- ☐ Farsighted

CHEST (BREAST)

- ☐ Breast lump/discharge

GENITOURINARY

- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Sexual Function Problems
- ☐ Discharge from penis

GYNECOLOGICAL

- ☐ Abnormal vaginal bleeding
- ☐ Problems with conception
- ☐ Problems with contraception
- ☐ Vaginal odor
- ☐ Vaginal discharge
- ☐ Painful intercourse

EARS/NOSE/THROAT/MOUTH

- ☐ Difficulty hearing/ringing in
- ☐ Hay fever/allergies
- ☐ Problems with teeth/gums

RESPIRATORY

- ☐ Cough/wheeze
- ☐ Difficulty breathing

MUSCULO-SKELETAL

- ☐ Muscle/joint pain

SKIN

- ☐ Rash or mole change(s)

PSYCHIATRIC

- ☐ Anxiety/stress
- ☐ Depression
- ☐ Problems with sleep

OTHER: _____

_____

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MINDEN PHYSICIAN PRACTICES
PATIENT'S RIGHTS AND RESPONSIBILITIES

Minden Physician Practices Patient's Bill of Rights and Responsibilities, distributed to all patients upon request at any time during patient care.

Patients of Minden Physician Practice shall have the right to:

- Be treated equally and receive care without regard to age, sex, religion, race or creed;
- Receive care that is not determined by patient's ability to pay for service;
- Confidentiality of his/her clinical records;
- Be informed of all costs and expected payment from other resources:
- Be treated with respect for the individual patient's comfort, dignity and privacy;
- Be informed of his/her rights in advance of care being provided;
- Access information contained in his/her clinical records within a reasonable time frame;
- Make decisions regarding his/her care;
- Formulate advance directives and have staff/practitioners to comply with those directives;
- Maintain personal privacy and receive care in a safe setting;
- Be free from verbal and physical abuse or harassment from staff.

The Practice understands that:

- Providing, to the extent possible, information needed by professional staff in caring for the patient;
- Following instructions and guidelines given by those providing health care services.

Communication Authorization

We take your medical confidentiality very seriously. We will not and cannot release information without your authorization. This authorization allows our staff members to speak only with individual(s) you designate in the event you are not available to receive phone calls or you have an adult individual that helps coordinate your medical care. As part of our Patient Privacy Policy, we will not leave any health information with any other persons unless you specifically authorize below.

_____ I do not authorize anyone to receive information regarding my medical care.
_____ I authorize my physician and staff of the clinic to speak with:

Name: _____ Phone _____

Relationship _____ [ ] Appointments [ ] Account [ ] Lab/Test Results [ ] Medical Care

Name: _____ Phone _____

Relationship _____ [ ] Appointments [ ] Account [ ] Lab/Test Results [ ] Medical Care

This authorization will remain in effect for one (1) year unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to this staff. I agree that should I desire to revoke this authorization, I will give written notices.

Printed Name of Patient or Representative: _____

Patient Signature: _____ Date/Time: _____

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CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements
so that we may proceed with the care and treatment ordered by your physician.

1. CONSENT TO SERVICES: I understand that a patient's care is directed by his/her attending physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician (s).

2. FINANCIAL AGREEMENT: I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the physician/clinic in accordance with the charges listed on the claim and, if applicable, the physician/clinic's charity care and discounted payment policies and state and federal law. The physician/clinic may provide, upon my request, a reasonable estimated of charges for items and services based on the charge fee schedule. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the physician/clinic may bill my insurance company or health benefit plan but is not required to do so. I agree and understand, except where prohibited by law, the financial responsibility for the services rendered belong to me, the undersigned. I further understand that the obligation to pay the physician/clinic may not be deferred for any reason, including pending legal actions against other parties to recover medical cost. The physician/clinic shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including radiologist, pathologist, emergency physician, anesthesiology, hospitalist, and others if applicable will bill separately for their services. For your convenience we accept cash, personal checks, MasterCard, Visa, Discover, and American Express.

3. REFERRALS: If your insurance plan requires a referral from a Primary Care Physician, it is your responsibility to make sure that the form is received PRIOR to scheduling an appointment. If you do not have your referral, the practitioner will be happy to see you, but you will be financially responsible for your charges.

4. PHYSICIAN/CLINIC TO ACT AS AGENT: I irrevocable assign and transfer to the physician/clinic all rights, benefits, and any other interest in connection with any insurance plan health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the physician/clinic of all insurance and health plan benefits payable for any services rendered. I agree that the insurers or plans payment to the physician/clinic shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal lay. I agree to cooperate with and take all steps reasonably requested by this physician/clinic to perfect, confirm, or validate this assignment. I also hereby authorize the physician/clinic, or its designee, to act on my half in any dispute with a managed care organization government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursing such appeals.

5. CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the clinic/physician to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, test messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

6. CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contact, unless I notify to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at the email address from the clinic/physician.

7. ELECTION TO ELETRONICALLY TRANSMIT MEDICAL INFORMAITON AT DISCHARGE: I authorize physician or clinic to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care providers(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or

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abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

8. ELECION TO PARTICIPATE IN HEALTH INFORMAITON EXCHANGE(S): I hereby authorize physician/clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which physician/clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and, in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which physician/clinic participates may be found in the Notice of Privacy Practices, which is available upon request, and this list may be updated from time to time if and when physician/clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.
9. PATIENT APPOINTMENT AND CONDUCT: I understand that unless cancelled 24 hours in advance, you are expected to appear on time for your appointment. Three (3) or more missed appointments in a 12 month period will result in a warning letter and five (5) or more missed appointments in a 12 month period may result in dismissal from the practice upon provider review and patients will be asked to seek treatment elsewhere. I am expected to be respectful to clinic staff and other patients. This includes use of appropriate language and heavier. Patients who use profane language or cause physical harm or threaten to cause harm will be dismissed from the practice.
10. HIPAA ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS: I understand and have been provided with a Notice of Privacy Practices and patient rights that provides a more complete description of my health care information uses and disclosures.
11. AUTHORIZATION TO DOWNLOAD PHARMACY INFORMATION: I understand and authorize physician/clinic to download my last 13 months of prescription history.
12. CONSENT TO PHOTOGRAPH: I consent to photographs, videos or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.
13. ADVANCE DIRECTIVE ACKNOWLEDGEMENT: I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. U understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

☐ Yes, I have executed an Advance Directive
☐ No, I have not executed an Advance Directive.

My signature indicates that I have read and fully understand this Patient Consent and Financial Agreement and have been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

_____ _____
Signature of Patient or Legal Representative Date/Time

_____ _____
Signature of Witness Date/Time

ADULT HEALTH FORM

NAME: _____ DOB: _____ PCP: _____

REASON FOR VISIT: _____ **RIGHT SIDE LEFT SIDE**

PAIN LEVEL: NOT AT ALL 1 2 3 4 5 6 7 8 9 10 WORSE PAIN

PREFERRED PHARMACY: _____ PHARMACY LOCATION: _____

ALLERGIES:

_____

_____

LIST ANY CURRENT MEDICATIONS (INCLUDING BIRTH CONTROL, VITAMINS, NON-PRESCRIPTION, ETC.):

MEDICATION	DOSE (E.G. MG/PILL)	HOW MANY TIMES PER DAY?

HAVE YOU HAD THE INFULENZA VACCINE? YES NO DATE OF VACCINE: _____

PNEUMONIA VACCINE IN THE LAST 5 YEARS? (>65 YEARS OLD) YES NO DATE OF VACCINE: _____

HAVE YOU RECEIVED THE COVID-19 VACCINE? YES NO VACCINE BRAND: _____ DATE OF VACCINE: _____

HAVE YOU EVER HAD THE SHINGLES VACCINE? YES NO DATE OF VACCINE: _____

HAVE YOU EVER HAD THESE SEXUALLY TRANSMITTED DISEASES?

HERPES: YES NO HIV: YES NO GONORRHEA: YES NO SYPHILLIS: YES NO

CHLAMYDIA: YES NO TRICHOMONAS: YES NO HPV: YES NO

OBSTETRIC HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____ HOW MANY LIVING CHILDREN DO YOU HAVE? _____

HOW MANY ELECTIVE ABORTIONS HAVE YOU HAD? _____ HOW MANY SPONTANEOUS ABORTIONS HAVE YOU HAD? _____

HAS ANY OF YOUR FAMILY HAD THE FOLLOWING CONDITIONS?

PLEASE SPECIFY MATERNAL OR PATERNAL SIDE OF FAMILY AND RELATION TO YOU

Example: Paternal side, aunt; Maternal side grandmother; brother/sister

	Mother (M) Father (P) Relation to you		**Mother (M) Father (P) Relation to you**
Anesthesia complications		Heart Problems	
Anxiety Disorder		Hepatitis	
Asthma		High Blood Pressure	
Bipolar Disorder		High Cholesterol	
Birth Defect or Inherited Disease		Kidney Disease	
Breast Cancer		Mental Retardation (Chromosome Disorders)	
Breast problems		Osteoporosis	
Cancer		Ovarian Cancer	
Cervical Cancer		Pulmonary Embolism	
Cystic Fibrosis		Seizures/Epilepsy	
Depression		Sickle Cell Disease/Trait	
Diabetes		Stroke	
Diverticulitis		Tay Sachs	
Endometriosis		Thalassemia	
Fibroids		Thyroid Problems	
Fragile X		Uterine Cancer	
Heart Disease		Varicose Veins	

SOCIAL HISTORY:

(CIRCLE ONE) MARRIED ENGAGED DOMESTIC PARTNER TOGETHER SEPARATED SINGLE WIDOWED

WHAT KIND OF WORK DO YOU DO? _____ HIGHEST GRADE YOU COMPLETED: _____

ABLE TO CARE FOR YOURSELF? YES NO ADVANCE DIRECTIVE: YES NO

BLIND OR HAVE DIFFICULTY SEEING? YES NO DEAF OR HAVE DIFFICULTY HEARING? YES NO

DO YOU HAVE DIFFICULTY CONCENTRATING, REMEMBER, OR DECISION MAKING? YES NO

DO YOU HAVE DIFFICULTY WALKING OR CLIMBING STAIRS? YES NO

DO YOU USE ASSISTIVE DEVICES TO WALK? WALKER, ROLLATOR, WHEELCHAIR, CANE

DO YOU HAVE DIFFICULTY DRESSING OR BATHING? YES NO

DO YOU HAVE DIFFICULTY DOING ERRANDS ALONE? YES NO

DO YOU HAVE TRANSPORTATION DIFFICULTIES? YES NO

DO YOU HAVE HOME HEALTH? YES NO IF SO, WHAT COMPANY? _____

EXERCISE LEVEL: NONE OCCASIONAL, MODERATE, HEAVY DIET: _____

ALCOHOL INTAKE: NEVER OCCASIONAL DAILY

CAFFIENE INTAKE: NONE OCCASIONAL, MODERATE, HEAVY

SMOKING HISTORY: NEVER FORMER DAILY OCCASIONALLY AMOUNT: _____ HOW MANY YEARS? _____

DO YOU VAPE? YES NO CHEWING TOBACCO: YES NO

HISTORY OF OR CURRENT DRUG USE: YES NO LIST ANY STREET DRUGS USED IN THE LAST YEAR: _____

DO YOU USE A SEATBELT ROUTINELY? YES NO DO YOU USE SUNSCREEN ROUTINELY? YES NO

WHO LIVES WITH YOU? _____ NUMBER OF CHILDREN IN THE HOUSE: _____

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL SEXUALLY ACTIVE: YES NO

WORK RELATED INJURY: YES NO AUTO RELATED INJURY: YES NO IS LITIGATION ONGOING? YES NO

IS BLOOD TRANFUSION ACCEPTABLE IN AN EMERGENCY? YES NO

SURGERIES (LIST TYPE OF SURGERY AND APPROXIMATE YEAR INCLUDING C-SECTION, TUBAL, D&C, BLADDER SUSPENSION):

Surgery Type and Year	Surgery Type and Year

List any hospitalizations not related to childbirth:

_____ _____

HEALTH HISTORY:

LAST MENSTRUAL PERIOD_____ LENGTH OF CYCLE FLOW_____ HOW MANY DAYS BETWEEN YOUR PERIODS? _____

DO YOU HAVE A PERIOD EVERY MONTH? YES NO IS YOUR FLOW: LIGHT MEDIUM HEAVY

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST PERIOD? _____

CURRENT BIRTH CONTROL: (INCLUDES VASECTOMY, TUBAL, CONDOMS, IUD, SHOTS, PILLS, PATCHES, RINGS) OR NONE: _____

IF POST-MENOPAUSAL, AGE AT MENOPAUSE: _____ LAST COLONOSCOPY? (IF OVER 50YRS OLD)_____

LAST BONE DENSITY TEST (IF OVER 50YRS OLD) _____ LAST MAMMOGRAM (IF OVER 40 YRS OLD) _____

LAST PROSTATE EXAM (IF APPLICABLE) _____ LAST PAP SMEAR (IF APPLICABLE) _____

LAST EYE EXAM _____

DO YOU OR HAVE YOU HAD COVID SYMPTOMS IN THE LAST 14 DAYS? YES NO

HAVE YOU BEEN IN CLOSE CONTACT WITH ANYONE HAVING COVID-19 SYMPTOMS OR TESTED POSITIVE FOR COVID-19? YES NO

HAVE **YOU** HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	Yes		Yes
Abnormal pap		Hearing Problems	
ADHD/ADD		Heart Disease	
Allergies		Heart Problems	
Anemia		Hepatitis	
Anesthesia complications		High Blood Pressure	
Anxiety Disorder		High Cholesterol	
Asthma		Hyperthyroidism	
Bipolar Disorder		Hypothyroidism	
Birth Defect or Inherited Disease		Infertility	
Bladder or Kidney Problems		Kidney Disease	
Blood Diseases		Liver Disease	
Breast Cancer		Lung Disease	
Breast problems		Muscle, Joint, or Bone	
Cancer		Osteoporosis	
Cervical Cancer		Ovarian Cancer	
Colon Cancer		Prostate Cancer	
COPD		Pulmonary Embolism	
Cystic Fibrosis		Seizures/Epilepsy	
Depression		Sickle Cell Disease	
Diabetes		Sickle Cell Trait	
Diverticulitis		Stroke	
Endometriosis		Tay Sachs	
Fibroids		Thalassemia	
Fibromyalgia		Thyroid Problems	
GERD/Reflux		Uterine Cancer	
GI problems		Varicose Veins	
Headaches/Migraines		Vision or Eye Problems	

Any other conditions not listed above: _____