## Jacqueline S. Orender, D.O., LLC

# REGISTRATION FORM

|  |
| --- |
| (Please Print) |
| PATIENT INFORMATION |
| Patient’s Last Name: | First: | MI: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital status (circle one): |
|  | Single / Mar / Div / Sep / Wid |
| Is this your legal name? | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: |
| ❑ Yes | ❑ No |  |  |  / / |  | ❑ M | ❑ F |
| Street address: | Social Security Number: | Primary phone number  |
| P.O. Box: | Race/Ethnicity (not required): | ( )Secondary phone number Please identify cell, work, home,etc( ) |
| City: | State: | ZIP Code: | E-Mail:  |
| Other family members seen here: |  |
| Patient’s Occupation: | Employer: | Employer phone no.: |
|  |  | ( ) |
|  |  **EMERGENCY CONTACT INFORMATION (Not living at same address)** |
| Name: | Relationship to Patient: Primary phone number:  |
|  |
| INSURANCE INFORMATION |
| **(Please give your insurance card to the receptionist)** |
| Person responsible for bill: | Birth date: | Address (if different): | Primary phone number |
|  |  / / |  | ( ) |
| Occupation:Employer: |  |  |  Social Security Number | Secondary phone number( ) |
| Employer address: | City/State | ZIP Code | Employer phone no.: |
|  |  |  | ( ) |
| Please indicate primary insurance | ❑ BCBS | ❑ Coventry | ❑ UMR | ❑ Tricare/UHC | ❑ AmeriGroup |
| ❑ Medicare | ❑ Other (Please Indicate) |  |  |  |  |
| Subscriber’s Name: | Subscriber’s SS #: | Birth date: | Group #: | Policy #: | Co-payment: |
|  |  |  / / |  |  | $ |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Step-Parent | ❑ Other (Please specify) |
| Name of secondary insurance (if applicable): | Subscriber’s Name: | Birth Date: | Subscriber’s SS#: |
|  |  |  / / |  |
| Policy #: | Group #: |  |  |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Step-Parent | ❑ Other (Please specify) |
|  |
| **AUTHORIZATION** |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jacqueline S. Orender, D.O., LLC or insurance company to release any information required to process my claims. |
|  |  |  |  |  |
|  | **Patient/Guardian signature** |  | **Date** |  |

JACQUELINE S. ORENDER, D.O., LLC

2305 TUCKER TERRACE

PITTSBURG, KANSAS 66762

PHONE 620.231.3132 FAX 620.231.3133

Jacqueline S. Orender, D.O.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby grant any rights necessary to Jacqueline S. Orender, D.O. LLC to obtain any and all medication history from whomever possesses such history for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Patient Name)

This authorization will remain in effect until such time that I revoke it in writing and/or cease to be a patient of Jacqueline S. Orender, D.O. LLC.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 (Self or Parent/Guardian)

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

Pharmacy(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2305 Tucker Terrace, Pittsburg, Kansas 66762 Office: 620-231-3132 Fax: 620-231-3133

**Policy Must be signed and dated below**

**JACQUELINE S ORENDER DO LLC FINANCIAL POLICY**

2305 TUCKER TERRACE, PITTSBURG, KS 66762 620-231-3132

Thank you, for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy we require you read and sign prior to any treatment.

All patients must complete our patient information before seeing the healthcare provider.

 **PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND DISCOVER.**

**(There will be a $30.00 charge for any returned checks)**

**Regarding Insurance:**

As a courtesy to you we can file your insurance for you. However, at the time of your visit we do expect payment in full. Please remember your insurance policy is a contract between you and your insurance company. We are not party to that contract unless it is a managed care policy that we have carefully negotiated prior to your visit to this office. In the event that we do not accept assignment of benefits the balance is your responsibility whether insurance pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

We cannot bill your insurance unless you have provided us with the necessary information. At your initial visit we do require a copy of all your insurance cards and a copy of your driver’s license. **We require notification of any changes in your insurance at any subsequent visits.**

After 60 days, if your insurance has not paid on your claim, this bill will be turned over to your responsibility and we will expect your payment in full. Upon prior approval we can bill this balance to your credit card. You will need to provide us with this information.

Regarding insurance plans where we are a participating provider. All co-pays, co-insurance and /or deductibles are to be paid at the time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the preceding paragraphs.

**Usual and Customary Rates:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

**Adult patients:**

Adult patients are responsible for full payment at time of service.

**Minor patients:**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified.

**No show/canceled appointments:**

**It is the policy of our office to charge for no show appointments as follows: upon the first no show you will receive written notification, second no show (within 12 months of first) you will be charged a minimum of $50 for the event and receive notification of intent to terminate provider patient relationship, third no show (within 12 months of first) you will be charged $50 and you will have terminated provider patient relationship. The charges will be the responsibility of the patient (or guardian if a minor) and will not be billed to insurance. Appointments canceled less than 1 (one) hour prior to the scheduled time will be considered a no show appointment. If you arrive more than 10 minutes after your scheduled appointment time it will be considered a no show.**

**NO SHOW OF INTIAL NEW PATIENT APPT WILL RESULT IN NOT BEING ACCEPTED INTO THE PRACTICE**

**Collections:**

It is the policy of our office to turn unpaid balances over to a collection agency unless extenuating circumstances are involved, communicated, documented and approved by our office. **If your account is turned over to a collection agency we will (under our discretion) view this as a termination of the patient\provider relationship.**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

**I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

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

Signature of Responsible Party

**Policy Must be signed and dated below**

JACQUELINE S. ORENDER, DO, LLC

FAMILY PRACTICE

Jacqueline S. Orender, D.O.

 Jacqueline S. Orender, D.O., LLC has a policy of drug screening patients. All new patients requesting medication refills **may** be required to test upon their initial visit. Existing patients being treated with medications in our clinic are subject to random testing, and all patients being prescribed controlled substances will be screened at regular intervals. We have implemented this practice in order to improve the quality of care given to our patients. We believe that we can better serve our patients with a clear understanding of all substances they are currently taking and how they are being metabolized.

 In the event that drug screen results indicate a patient is non-compliant with treatment, we will create an action plan. This will be tailored to suit that patient’s particular needs. Drug screens are not being read at our clinic; however, we will collect on spot samples and submit them to be processed by an outside laboratory.

 We appreciate your continued patronage to our clinic and look forward to serving your needs in the future.

Sincerely,

Jacqueline S. Orender, D.O.

**I HAVE READ THE DRUG SCREEN POLICY AND I UNDERSTAND AND AGREE TO THIS POLICY.**

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

Signature of Patient

 2305 Tucker Terrace, Pittsburg, Kansas 66762 Office: 620-231-3132 Fax: 620-231-3133

**JACQUELINE S. ORENDER DO, LLC**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize

(Patient’s name here) (Date of birth)

**Jacqueline S Orender D.O. LLC** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release to or receive from

Name or Person/Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method of Delivery (check applicable box):**

 Pick up copies of the medical record in Department

 Copies to be mailed

 Medical Record to be faxed (for immediate patient care only) Fax # **(620) 231-3133**

**Purpose of Release:**

 Review of records for: **◊** 2nd Opinion **◊** Specialist

 Continuity of care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Transfer of care

**Information to be Released:**

 I authorize the release of any and all information contained in my medical records; including those which may contain ***potentially sensitive information*** concerningtreatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

 I authorize only the release of the following records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I also understand that I may revoke this authorization at any time by signing a Revocation Form at Jacqueline S. Orender DO, LLC and returning it to the Information Privacy/Security Officer. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

This authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_ or within one (1) year of the date signed. A photostatic or fax copy of this authorization shall be considered as effective and valid as the original.

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

 (Patient or legal representative)

2305 TUCKER TERRACE · PITTSBURG, KS 66762 · PHONE (620)231-3132 · FAX (620)231-3133

**Consent Must be signed and dated below**

**HIPAA Compliance Patient Consent Form**

 Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent (see our website or ask front desk for copy of the notice of privacy practices). The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

 • Protected health information may be disclosed or used for treatment, payment, or healthcare operations. • The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. • The practice may condition receipt of treatment upon execution of this consent.

Document must be signed and dated to be accepted into practice. By signing you confirm that we can call you and leave messages for appointment reminders etc.

May we discuss your medical condition with any member of your family?

YES NO

If YES, please name the members allowed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent was signed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PRINT NAME PLEASE)

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

|  |  |  |
| --- | --- | --- |
| **JACQUELINE S. ORENDER, D.O.**FAMILY PRACTICE2305 Tucker TerracePittsburg, Ks 66762Office: 620-231-3132Fax: 620-231-3133 | Original Date: |  |
| Dates Revised: |  |
|  |  |
|  |
|  |
| HEALTH HISTORY QUESTIONNAIRE |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name (Last, First, M.I.): |  | 🞎 M 🞎 F | DOB: |  |
| Marital status:  | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed |
| Previous or referring doctor: |  | Date of last physical exam: |  |
|  |
| PERSONAL HEALTH HISTORY |
|  |
| Childhood illness: | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio |
| Immunizations and dates: | 🞎 Tetanus |  | 🞎 Pneumonia |  |
| 🞎 Hepatitis |  | 🞎 Chickenpox |  |
| 🞎 Influenza |  | 🞎 MMR Measles, Mumps, Rubella |  |
| List any medical problems that other doctors have diagnosed |
|  |
|  |
|  |
|  |
| Surgeries |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Other hospitalizations |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| Have you ever had a blood transfusion? | 🞎 | Yes | 🞎 | No |
| Please turn to next page |

|  |
| --- |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers |
| Name the Drug | Strength | Frequency Taken |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Allergies to medications |
| Name the Drug | Reaction You Had |
|  |  |
|  |  |
|  |  |
|  |
| HEALTH HABITS AND PERSONAL SAFETY |
|  |
| All questions contained in this questionnaire are optional and will be kept strictly confidential. |
| Exercise | 🞎 Sedentary (No exercise) |
| 🞎 Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| 🞎 Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) |
| 🞎 Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) |
| Diet | Are you dieting? | 🞎 | Yes | 🞎 | No |
| If yes, are you on a physician prescribed medical diet? | 🞎 | Yes | 🞎 | No |
| # of meals you eat in an average day? |
| Rank salt intake | 🞎 Hi | 🞎 Med | 🞎 Low |
| Rank fat intake | 🞎 Hi | 🞎 Med | 🞎 Low |
| Caffeine | 🞎 None | 🞎 Coffee | 🞎 Tea | 🞎 Cola |
| # of cups/cans per day? |
| Alcohol | Do you drink alcohol? | 🞎 | Yes | 🞎 | No |
| If yes, what kind? |
| How many drinks per week? |
| Are you concerned about the amount you drink? | 🞎 | Yes | 🞎 | No |
| Have you considered stopping? | 🞎 | Yes | 🞎 | No |
| Have you ever experienced blackouts? | 🞎 | Yes | 🞎 | No |
| Are you prone to “binge” drinking? | 🞎 | Yes | 🞎 | No |
| Do you drive after drinking? | 🞎 | Yes | 🞎 | No |
| Tobacco | Do you use tobacco? | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | 🞎 Chew - #/day | 🞎 Pipe - #/day | 🞎 Cigars - #/day |
| 🞎 # of years | 🞎 Or year quit |
| Drugs | Do you currently use recreational or street drugs? | 🞎 | Yes | 🞎 | No |
| Have you ever given yourself street drugs with a needle? | 🞎 | Yes | 🞎 | No |
| Sex | Are you sexually active? | 🞎 | Yes | 🞎 | No |
| If yes, are you trying for a pregnancy? | 🞎 | Yes | 🞎 | No |
| If not trying for a pregnancy list contraceptive or barrier method used: |
| Any discomfort with intercourse? | 🞎 | Yes | 🞎 | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? |  |  |  |  |
| 🞎 | Yes | 🞎 | No |
| Personal Safety | Do you live alone? | 🞎 | Yes | 🞎 | No |
| Do you have frequent falls? | 🞎 | Yes | 🞎 | No |
| Do you have vision or hearing loss? | 🞎 | Yes | 🞎 | No |
| Do you have an Advance Directive or Living Will? | 🞎 | Yes | 🞎 | No |
| Would you like information on the preparation of these? | 🞎 | Yes | 🞎 | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? |  |  |  |  |
| 🞎 | Yes | 🞎 | No |

|  |
| --- |
| FAMILY HEALTH HISTORY |
|  |
|  | Age | Significant Health Problems |  | Age | Significant Health Problems |
| Father |  |  | Children | 🞎 M🞎 F |  |  |
| Mother |  |  | 🞎 M🞎 F |  |  |
| Sibling | 🞎 M🞎 F |  |  | 🞎 M🞎 F |  |  |
| 🞎 M🞎 F |  |  | 🞎 M🞎 F |  |  |
| 🞎 M🞎 F |  |  | GrandmotherMaternal |  |  |
| 🞎 M🞎 F |  |  | GrandfatherMaternal |  |  |
| 🞎 M🞎 F |  |  | GrandmotherPaternal |  |  |
| 🞎 M🞎 F |  |  | GrandfatherPaternal |  |  |

|  |
| --- |
| MENTAL HEALTH |
|  |
| Is stress a major problem for you? | 🞎 | Yes | 🞎 | No |
| Do you feel depressed? | 🞎 | Yes | 🞎 | No |
| Do you panic when stressed? | 🞎 | Yes | 🞎 | No |
| Do you have problems with eating or your appetite? | 🞎 | Yes | 🞎 | No |
| Do you cry frequently? | 🞎 | Yes | 🞎 | No |
| Have you ever attempted suicide? | 🞎 | Yes | 🞎 | No |
| Have you ever seriously thought about hurting yourself? | 🞎 | Yes | 🞎 | No |
| Do you have trouble sleeping? | 🞎 | Yes | 🞎 | No |
| Have you ever been to a counselor? | 🞎 | Yes | 🞎 | No |

|  |
| --- |
| WOMEN ONLY |
|  |
| Age at onset of menstruation: |
| Date of last menstruation: |
| Period every \_\_\_\_\_ days |
| Heavy periods, irregularity, spotting, pain, or discharge? | 🞎 | Yes | 🞎 | No |
| Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ |
| Are you pregnant or breastfeeding? | 🞎 | Yes | 🞎 | No |
| Have you had a D&C, hysterectomy, or Cesarean? | 🞎 | Yes | 🞎 | No |
| Any urinary tract, bladder, or kidney infections within the last year? | 🞎 | Yes | 🞎 | No |
| Any blood in your urine? | 🞎 | Yes | 🞎 | No |
| Any problems with control of urination? | 🞎 | Yes | 🞎 | No |
| Any hot flashes or sweating at night? | 🞎 | Yes | 🞎 | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | 🞎 | Yes | 🞎 | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | 🞎 | Yes | 🞎 | No |
| Date of last pap and rectal exam? |
|  |
| MEN ONLY |
|  |
| Do you usually get up to urinate during the night? | 🞎 | Yes | 🞎 | No |
| If yes, # of times \_\_\_\_\_ |
| Do you feel pain or burning with urination? | 🞎 | Yes | 🞎 | No |
| Any blood in your urine? | 🞎 | Yes | 🞎 | No |
| Do you feel burning discharge from penis? | 🞎 | Yes | 🞎 | No |
| Has the force of your urination decreased? | 🞎 | Yes | 🞎 | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | 🞎 | Yes | 🞎 | No |
| Do you have any problems emptying your bladder completely? | 🞎 | Yes | 🞎 | No |
| Any difficulty with erection or ejaculation? | 🞎 | Yes | 🞎 | No |
| Any testicle pain or swelling? | 🞎 | Yes | 🞎 | No |
| Date of last prostate and rectal exam? | 🞎 | Yes | 🞎 | No |
|  |
| OTHER PROBLEMS |
|  |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 🞎 | Skin | 🞎 | Chest/Heart | 🞎 | Recent changes in: |
| 🞎 | Head/Neck | 🞎 | Back | 🞎 | Weight |
| 🞎 | Ears | 🞎 | Intestinal | 🞎 | Energy level |
| 🞎 | Nose | 🞎 | Bladder | 🞎 | Ability to sleep |
| 🞎 | Throat | 🞎 | Bowel | 🞎 | Other pain/discomfort: |
| 🞎 | Lungs | 🞎 | Circulation |  |  |