



# Eastport Health Care, Inc.

*Our Specialty is YOU!*

Rowland B. French Medical Center  
Vogl Behavioral Health Center  
30 Boynton Street  
Eastport, Maine 04631  
Phone: 207-853-6001  
Fax: 207-853-6180

Welcome to EHC!

Thank you for your interest in becoming our patient! Our goal is to provide high quality health care and we are excited to be your Patient Centered Medical Home.

Please complete and return the enclosed documents to our office to begin the process of becoming our patient. All forms must be filled out as completely as possible. **Missing documents or incomplete forms will be sent back to you which will delay your initial appointment.**

1. Registration form
2. Authorization to Release Health Information form (This is required for us to request past medical records. Our providers must review past medical records before deciding if they are able to accept you as a patient.)
3. Health History form

This process could take anywhere between 3-6 weeks to obtain all of the necessary information and present it to a provider. Once we receive all of the necessary information, a provider has 7 business days to review your information. If one of our providers can provide your care, our reception staff will contact you to schedule an initial appointment. In the event a provider is not able to provide your care, we will provide you with information for other local medical providers.

If you have any questions or concerns, please contact us at any of our office locations.

*Eastport Health Care, Inc. is an Equal Opportunity Employer and Provider*

**Machias Behavioral Health**  
160 Dublin St.  
Machias, ME 04654  
Phone: (207)-255-3400  
Fax: (207)-255-3401

**Machias Family Practice**  
160 Dublin St.  
Machias, ME 04654  
Phone: (207)-255-8290  
Fax: (207)-255-4109

**Machias Pediatrics**  
160 Dublin St.  
Machias, ME 04654  
Phone: (207)-255-0980  
Fax: (207)-255-3897

## **Kulasihkulpon peciyayin EHC! (Passamaquoddy)**

Woliwon eli-tpitahatomon kiseltomuwinen ktankeyulonen! Npawatomonen kulankeyulonen, naka nulitahasipon eli yut-oc kil ktaspihtolom.

Mec-op-al kisi-psonehtun naka ktapaciptun ntahpisomonnuk yuhtol wikhikonol, weci-kisi-mace luhkatomek eli-koti-mace-ankeyuwulek. Psi-te pilaskul cuwi-'kihka-psonehtasuwol.

Keskahtasikil pilaskul naka wikhikonol skat nekka-psonehtasinuhk cu-oc wesuwe-pcitahkewkenol, nakahc amsqahs keti-nemiyukiyin-oc metsiyewiw.

Nehehtaw iyyin qecikesuwakonol kosona 'tomitahasuwakonol, mec-op-al kisi-mattoktehtumuwinen tan-ote ehtek ntahpisomonnul.

## **Bienvenue chez EHC ! (French)**

Merci de vouloir devenir l'un de nos patients ! Notre objectif est de fournir des soins de santé de haute qualité et nous sommes heureux d'être votre maison médicale centrée sur le patient.

Veillez remplir et renvoyer les documents ci-joints à notre bureau afin d'entamer votre procédure d'inscription en tant que patient. Tous les formulaires doivent être remplis aussi complètement que possible. Les documents manquants ou les formulaires incomplets vous seront renvoyés, ce qui retardera votre rendez-vous initial.

1. Formulaire d'inscription
2. Formulaire d'autorisation de divulgation de renseignements médicaux. (Nous en avons besoin pour demander des antécédents médicaux. Nos prestataires doivent examiner vos antécédents médicaux avant de décider s'ils sont en mesure de vous accepter en tant que patient.)
3. Formulaire de l'historique de santé.

Lorsque nous aurons reçu toutes les informations nécessaires, un prestataire dispose de 7 jours ouvrables pour examiner vos informations. Si vous êtes accepté comme patient, notre personnel d'accueil vous contactera pour fixer un premier rendez-vous. Dans le cas où un prestataire ne serait pas en mesure de vous accepter en tant que patient, nous vous fournirons des informations pour d'autres prestataires médicaux locaux.



Eastport Health Care Inc.  
Patient Registration Form  
*Our Specialty is YOU!*

<b>Current Patient Information (Please Print)</b>				
Last Name:	First Name:	Middle Name:	Preferred Name:	
Street Address	PO Box	City	State	Zip
Home Phone: Primary __Y __N	Cell Phone: Primary __Y __N	Work Phone:	Email: (see below)	
Would you like to sign up for our patient portal? ____ Yes (please list email above) ____ Declined				
Date of Birth:	Marital Status:	Social Security #:	Gender:	Primary Caregiver:
Guarantor Name:		Guarantor Address:		Guarantor Phone:
Relationship to Patient:		Social Security #:	Date of Birth:	
Emergency Contact:	Relationship to Patient:	Home Phone:	Cell Phone:	
<b>Medical Insurance Information</b>				
Primary Medical Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
Secondary Medical Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
<b>Dental Insurance Information</b>				
Primary Dental Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
Secondary Dental Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
<b>Notice of Privacy Practice, Consent, and Assignment of Benefits</b>		<b>Payment and No Show Policy</b>		
<p>I hereby assign my insurance benefits to be paid directly to the Provider. I authorize the Provider to release any medical/dental information required to process claims. I authorize my Provider's office to contact me by telephone to remind me of my appointment. I acknowledge that I have reviewed the Consent for Medical and Dental Treatment, the Notice of Privacy Practices, and Patient Centered partnership of Care patient rights forms. By signing below I acknowledge that I have read and agree to the statements listed above and any questions or concerns I have were addressed.</p> <p><b>Patient/Parent/Guarantor/Authorized Representative Signature:</b></p>		<p>Quality Care for our patients is our priority. EHC has developed a Payment Policy and No Show Policy to assist you in understanding your financial obligations and the impact on our practice when a patient "no-shows". By signing below, I acknowledge that I have reviewed, understand, and agree to adhere to the policies.</p> <p><b>Patient/Parent/Guarantor/Authorized Rep. Signature:</b></p>		
Date:		Date:		



# Eastport Health Care, Inc.

*Our Specialty is YOU!*

Rowland B. French Medical Center  
 Vogl Behavioral Health Center  
 30 Boynton Street  
 Eastport, Maine 04631  
 Phone: 207-853-6001  
 Fax: 207-853-6180

Eastport Health Care, Inc. is a Federally Qualified Health Center funded by the Bureau of Primary Health Care. As a requirement for funding, we are responsible for collecting the following data on all of our patients. If you choose not to share this data, please indicate by checking "declined".

Annual income: \$\_\_\_\_\_  per year  per month  every two weeks  weekly  Declined

Number of Household Members: \_\_\_\_\_  Declined

Agricultural Worker:  Migrant  Seasonal  No  Declined

School-Based Health Center Patient:  Yes  No  Declined

Name of School: \_\_\_\_\_

Homeless Status:  Yes  No  Declined      Veteran Status:  Yes  No  Declined

Public Housing Patient:  Yes  No  Declined      Preferred Language:  English  Other  Declined

Race:  African American  American Indian  Alaskan Native  Asian  Other Race  White  Declined

Ethnicity:  Central American  Cuban  Dominican  Hispanic or Latino/Spanish  Latin American/Latin, Latino  
 Mexican  Non-Hispanic or Latino  Puerto Rican  South American  Spaniard  Declined

Sex:  Male  Female  Chose not to disclose

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
 Patient/Parent/Guarantor/Authorized Representative

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

*Eastport Health Care, Inc. is an Equal Opportunity Employer and Provider*

Machias Behavioral Health  
 160 Dublin St.  
 Machias, ME 04654  
 Phone: (207)-255-3400  
 Fax: (207)-255-3401

Machias Family Practice  
 160 Dublin St.  
 Machias, ME 04654  
 Phone: (207)-255-8290  
 Fax: (207)-255-4109

Machias Pediatrics  
 160 Dublin St.  
 Machias, ME 04654  
 Phone: (207)-255-0980  
 Fax: (207)-255-3897



## **CONSENT FOR TREATMENT AT EASTPORT HEALTH CARE**

1. I am aware that the practice of medicine/dentistry is not an exact science and that EHC offers no guarantee concerning any treatments or examinations that I may have here.
2. I understand EHC and its employees may use the information contained in my record for proper medical/dental purposes, and for clinical improvement audits.
3. I authorize the medical/dental staff at EHC to conduct any diagnostic examinations, test and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for a particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

**SIGNATURE:** By signing below I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

\_\_\_\_\_  
Patient/Authorized Representative\* Signature

\_\_\_\_\_  
Date

\*If signed by an Authorized Representative

\_\_\_\_\_  
Printed name of Authorized Representative

\_\_\_\_\_  
Source of Authority (e.g., guardian, Power of attorney)



**Eastport Health Care Inc.**  
**Medical Records**  
 30 Boynton Street  
 Eastport, Maine 04631  
 (207) 853 - 6001 Fax (207) 853-6180

**Patient Name:**  
**Patient Former Name or Alias:**  
**Patient Address:**  
  
**Date of Birth:**  
**Patient Phone:**

### Authorization to Release Health Information

I give my permission for EHC (Eastport Health Care) and its employees to:

- Get My Medical Information** indicated below **FROM** **OR**  **Send My Medical Information** indicated below **TO**

Name of Person or Organization: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To be  Mailed  Faxed  Emailed (if requesting secure electronic delivery) \_\_\_\_\_

Email Address

#### Dates of Care or Dates of Records

**All Records** \_\_\_\_\_ (**Note:** check "All Records" ONLY if all medical records are needed. Sensitive Medical Information is not included unless selected below.)

**OR** I wish to release **Only those items selected below:**

- |  |   |
|--|---|
| <input type="checkbox"/> Clinic Records _____    | <input type="checkbox"/> Immunization Records _____ |
| <input type="checkbox"/> Lab Reports _____       | <input type="checkbox"/> Hospital Records _____     |
| <input type="checkbox"/> Radiology Reports _____ | <input type="checkbox"/> Summary Records _____      |
| <input type="checkbox"/> Other Records _____     |   |

#### Sensitive Medical Information (Substance Abuse, Mental Health, HIV/AIDS): THIS SECTION MUST BE COMPLETED

I understand what may happen if I release the following sensitive information and have indicated which items I do wish to release and/or those I do not wish to release below.

#### Dates of Care or Dates of Records

- I DO** /  **I DO NOT** wish to release HIV/AIDS records \_\_\_\_\_
- I DO** /  **I DO NOT** wish to release Mental Health Treatment records \_\_\_\_\_
- I DO** /  **I DO NOT** wish to release Alcohol/Drug Abuse Treatment records \_\_\_\_\_ (**I understand this information cannot be redisclosed without my specific consent**)

I authorize the release of the Sensitive Medical Information selected above without review UNLESS I initial here \_\_\_\_\_.

#### The purpose of the disclosure is (check where applicable):

- Coordination of Medical Care  Transfer of Medical Care  Insurance  Legal  Disability  School Entry  Referral
- For Personal Use, please explain \_\_\_\_\_  Other, specify \_\_\_\_\_

#### Other Instructions:

Please use this space to indicate any special requests, information you do not wish disclosed, a different event or expiration for this Authorization, or any other instructions which may assist us with your request.

This Authorization is for  a one-time disclosure OR  multiple disclosures (Note: authorization for disclosure of certain mental health records cannot be continuing authorizations)

This Authorization expires: \_\_\_\_\_ Note: If left blank, this form will expire in ninety (90) days for one-time disclosures or in (1) year for multiple disclosures of health records. **Exception:** Six (6) months for children in residential and foster care.



**Eastport Health Care Inc.**  
**Medical Records**  
 (207) 853-6001 Fax (207) 853-6180

**Patient Name:**  
**Date of Birth:**

This Authorization Form is voluntary and you may refuse to sign it. You may also cross out any words on this form that you do not agree with. Refusal to sign the form will not block your ability to receive health care services or payment for services; except that refusing to sign will mean you will not receive health services if those services are only to provide your Medical Information to someone else which requires a signed Authorization form. Refusal to sign this form may cause improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other negative outcomes. I understand that certain health information I authorize to be disclosed may be subject to redisclosure by the recipient and no longer protected.

You may have a copy of this form if you wish. In addition, you have the right to review the records before they are sent. You also have the right to receive a copy of the information requested in this form. Patients may receive a personal copy of these records at no charge, while a fee will be assessed for third party requests. The current prices are available where you receive care or by calling Medical Records at (207) 853-6001. The requested information will be sent within thirty (30) days of when you submit a completed form and pay any required fee.

- If you ask that copies of the requested information be sent by mail, EHC will send that information on a compact disc unless you have given other instructions.
- If you ask for e-mail copies of the information, you must provide a valid e-mail address. Your records will be given as Adobe PDF files on EHC's secure messaging portal. EHC will send an email to the email address you provide with instructions on how to access your Medical Information through the secure messaging portal.

You can revoke this authorization at any time by sending a written request to the person or entity that is sending us the records, or to us if we are the ones releasing your records to an outside entity or person. If you cancel this Authorization, it will not stop or change any action already taken by EHC or any other entity named in this release that was taken in reliance on this authorization and prior to receiving your notice to cancel. Canceling this form can cause denial of health benefits or other insurance coverage benefits.

**I have read this Authorization form and I understand it.** By signing below, I give my permission for EHC to release the Medical Information as described in this form and I release EHC, its employees, directors, officers and medical staff, from legal responsibility or liability for the release of the Medical Information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Representative)

Print Name: \_\_\_\_\_

If not signed by the Patient, please indicate the authority to act for the patient:  Parent  Guardian  Power of Attorney  
*[Please attached proof of authority if signing as a guardian or under a power of attorney.]*

**FOR OFFICE USE ONLY**

**Notice to Recipient of Prohibition on Redisclosure**

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice Regarding Sensitive Medical Information**

**For persons/organizations receiving mental health information or HIV provided by EHC:** This information has been disclosed to you from records protected by State confidentiality laws (22 M.R.S.A. § 1711-C(6)(A)(2) and/or 5 M.R.S.A. § 19201 *et seq.*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

**EHC Use Only:** Received By: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_\_\_  
 Rev. 4/27/2018



**EHC Patient Portal Access and Consent**

Eastport Health Care is pleased to offer established patients access to our online Patient Portal managed by Athenahealth, our electronic health record platform. The patient portal is a secure way to access your health information, contact your provider with questions, request refills, view appointments, view or pay your EHC bill and much more! Please read and sign below to request access or give permission to a family member/caretaker to access.

**Important:** By signing below, you understand that your patient portal contains personal health information including, but not limited to: diagnosis information, medication lists, allergy lists, past medical history information, visit summaries, mental health information, billing information, and appointment information. Eastport Health Care is not responsible for the misuse, unauthorized disclosure, or other use of information obtained by yourself or person you have given permission to through the patient portal. You are responsible for the creation and privacy of your portal password. Minor patients under the age of 13 do not have the ability to create a patient portal account. If requested, it will be created for the use of parents/legal guardians. Patients 18 and over must provide written permission for family members, caretakers, or others to have access to their patient portal. Permission may be revoked by the patient at any time by contacting Eastport Health Care.

Our patient portal may be accessed at: <https://8309.portal.athenahealth.com> or through the patient portal log-in link on our webpage: [www.eastporthealth.org](http://www.eastporthealth.org).

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Yes, please sign me up for the portal!

Email address: \_\_\_\_\_

I am the parent/legal guardian of the minor child above and wish to have access to their patient portal.

Parent/Guardian Name: \_\_\_\_\_

Email address: \_\_\_\_\_

I authorize access of my patient portal to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email address: \_\_\_\_\_

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

*Eastport Health Care, Inc. is an Equal Opportunity Employer and Provider*

**Machias Behavioral Health**  
 160 Dublin St.  
 Machias, ME 04654  
 Phone: (207)-255-3400  
 Fax: (207)-255-3401

**Machias Family Practice**  
 160 Dublin St.  
 Machias, ME 04654  
 Phone: (207)-255-8290  
 Fax: (207)-255-4109

**Machias Pediatrics**  
 160 Dublin St.  
 Machias, ME 04654  
 Phone: (207)-255-0980  
 Fax: (207)-255-3897



# Eastport Health Care, Inc.

*Our Specialty is YOU!*

Rowland B. French Medical Center  
Vogl Behavioral Health Center  
30 Boynton Street  
Eastport, Maine 04631  
Phone: 207-853-6001  
Fax: 207-853-6180

## Authorization for Portal Communication

You may be contacted via text, email, or automated phone call for appointment reminders, health reminders, notification of a new bill, a new message from your provider, etc. Please use the spaces below to authorize consent to each of the three methods of contact.

Consent to text: \_\_\_\_ Yes \_\_\_\_ No

Consent to email: \_\_\_\_ Yes \_\_\_\_ No

Consent to call: \_\_\_\_ Yes \_\_\_\_ No

*Eastport Health Care, Inc. is an Equal Opportunity Employer and Provider*

**Machias Behavioral Health**  
160 Dublin St.  
Machias, ME 04654  
Phone: (207)-255-3400  
Fax: (207)-255-3401

**Machias Family Practice**  
160 Dublin St.  
Machias, ME 04654  
Phone: (207)-255-8290  
Fax: (207)-255-4109

**Machias Pediatrics**  
160 Dublin St.  
Machias, ME 04654  
Phone: (207)-255-0980  
Fax: (207)-255-3897

## Pediatric Medical Health History Form

*This form will help your clinician better understand you or your child's medical concerns and conditions. If you are uncomfortable with any question, do not answer it.*

**Please provide your best guess when a date is requested.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name of Person Completing this form: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Preferred Provider: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

**MEDICATIONS** (Prescription and **non-prescription medicines**, vitamins, home remedies, birth control pills, herbs, oxygen, CPAP)

Medication and Dose	Instructions	Medication and Dose	Instructions

**ALLERGIES** (Medicines, Seasonal, Environmental, Foods)

Allergy	Reaction	Allergy	Reaction

### PERSONAL MEDICAL HISTORY

*Please list any medical problem(s), hospitalizations, surgeries, serious illnesses, or accidents you have ever had.*

History	Date

*Please make a check mark next to any of the below developmental concerns.*

Concern	Yes	Concern	Yes
Physical Development		School Experience	
Behavior		Bathroom/Toilet Habits	
Eating Habits		Discipline	
Sleeping Habits		Other *	

*\*Other problems, please specify:* \_\_\_\_\_

If you have ever had a blood transfusion, please specify date(s) \_\_\_\_\_

Would a blood transfusion be acceptable in an emergency? \_\_\_ No \_\_\_ Yes

Do you have any religious or spiritual beliefs? \_\_\_ No \_\_\_ Yes

Last Dental Exam? \_\_\_\_\_ Last Eye Exam? \_\_\_\_\_

### BIRTH HISTORY

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Length of stay at the hospital after birth: \_\_\_\_\_

# Pediatric Medical Health History Form

Please make a check mark if the mother experienced any of the following conditions during the pregnancy.

Condition	Yes	Condition	Yes
High Blood Pressure	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>
Bleeding/Clotting Disorder	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Other *	<input type="checkbox"/>

\*Other problems, please specify: \_\_\_\_\_

## FAMILY HISTORY

Please list any biological family members that have ever had any of the following conditions.

Condition	Family Member	Condition	Family Member
Alcoholism/Substance Abuse		COPD	
Anemia		Heart disease/Heart attack	
Anxiety		Heart Failure	
Asthma		Heart Valve problems	
Cancer (type)		High blood pressure	
Depression		Kidney disease	
Diabetes (type)		Stroke	
Seizures		Other*	

\*Other problems, please specify: \_\_\_\_\_

Does the child have consistent child-care (baby-sitter, pre-school, day care)? \_\_\_\_\_

Please list all people in the household and any siblings (including those that may have passed away).

Name	Relationship	Date of Birth

## HEALTH MAINTENANCE

Please enter the date of your most recent immunizations and tests.

Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ Tetanus \_\_\_\_\_ HPV \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_  
 MMR \_\_\_\_\_ Varicella (chicken pox) \_\_\_\_\_ PPD \_\_\_\_\_

## SOCIAL HISTORY (This section is for teenagers and is to be completed by the patient)

*Tobacco/Alcohol/Drug Use*

Do you smoke? \_\_\_ No \_\_\_ Yes      Current Smoker: \_\_\_ packs/day \_\_\_ # of years

Do you use any of the following? \_\_\_ Pipe \_\_\_ Cigar \_\_\_ Snuff \_\_\_ Chew \_\_\_ E-cigarettes/Vape

Do you drink alcohol? \_\_\_ No \_\_\_ Yes, # drinks/week \_\_\_\_\_

Do you use any street drugs? \_\_\_ No \_\_\_ Yes, please specify: \_\_\_\_\_

Have you ever used street drugs? \_\_\_ No \_\_\_ Yes, please specify: \_\_\_\_\_

# Pediatric Medical Health History Form

Have you ever injected street drugs?  No  Yes, please specify: \_\_\_\_\_

*Diet/Exercise*

# meat servings per day: \_\_\_\_\_ # fresh fruit/vegetable servings per day: \_\_\_\_\_

# of snacks per day: \_\_\_\_\_ # sweetened beverages per day: \_\_\_\_\_ # caffeinated beverages per day: \_\_\_\_\_

Do you exercise regularly?  No  Yes, please specify: \_\_\_\_\_

## **SOCIOECONOMICS (This section is for teenagers and is to be completed by the patient)**

Are you currently employed?  No  Yes Occupation: \_\_\_\_\_

Education completed: \_\_\_\_\_

Marital status:  Single  M  Sep  D  W  Cohabiting

Spouse/Partner's name: \_\_\_\_\_ Number of children: \_\_\_\_\_

## **WOMEN'S GYNECOLOGIC HISTORY (This section is for teenagers and should be completed by the patient)**

# pregnancies: \_\_\_\_\_ # deliveries: \_\_\_\_\_ # miscarriages: \_\_\_\_\_ # abortions: \_\_\_\_\_ Age at first childbirth: \_\_\_\_\_

1st day, most recent period: \_\_\_\_\_ Age at 1st period: \_\_\_\_\_ Frequency of periods: \_\_\_\_\_

Length of each period: \_\_\_\_\_ Do you have any concerns about your periods?  No  Yes

Ever had an abnormal PAP?  No  Yes: results \_\_\_\_\_

## **SEXUALITY (This section is for teenagers and should be completed by the patient)**

Sexually Active:  Yes  No

Current sex partner(s) is/are:  male  female

If sexually active, do you practice safe sex (use condoms)?  NA  No  Yes

Have you ever had any sexually transmitted diseases (STDs)?  No  Yes

If yes, please specify: \_\_\_\_\_ date \_\_\_\_\_

Are you interested in being screened for sexually transmitted diseases?  No  Yes

Ever been exposed to HIV/AIDS?  No  Yes

Have you been tested for HIV?  No  Yes: results \_\_\_\_\_

Would you like to be tested for HIV?  No  Yes

Other concerns? \_\_\_\_\_

## **SAFETY (This section is for teenagers and should be completed by the patient)**

Do use seatbelts consistently?  No  Yes

Do you have a smoke detector in your home?  No  Yes

Is violence at home a concern for you?  No  Yes

Do you feel safe in your current relationship?  N/A  No  Yes

Do you have a gun in your home?  No  Yes

Do you use a bike helmet regularly?  N/A  No  Yes

Other concerns? \_\_\_\_\_

## **EMOTIONS (This section is for teenagers and should be completed by the patient)**

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

No  Yes

During the past month, have you often been bothered by little interest or pleasure in doing things?

No  Yes

# Pediatric Medical Health History Form

## REVIEW OF SYSTEMS

Please make a check mark next to any symptoms you have had in the **last couple of days**:

Constitutional		Respiratory	
Unintended Weight Loss		Cough	
Unintended Weight Gain		Shortness of breath or difficulty breathing	
Poor Appetite		Wheezing	
Fever		Coughing up sputum	
Chills		Coughing up blood	
No Energy		Chest tightness	
Eyes		Gastrointestinal	
Pain		Difficulty swallowing	
Blurry vision		Abdominal pain	
Double Vision		Heartburn	
Redness		Nausea	
Itchiness		Vomiting	
Swelling		Diarrhea	
Discharge		Blood in stool	
		Mucus in stool	
Ears, Nose, Throat		Change in bowel habits	
Ear Pain		Loss of bowel control	
Discharge			
Hearing Loss		Genitourinary	
ringing in the ears		Discharge	
Sinus Pressure		Blood in urine	
Drooling		Pain with urination	
Facial Swelling		Increased frequency or urgency	
Sore Throat		Urinary loss of control	
Mouth Lesions		Flank pain	
Dental Pain		Testicular pain or swelling	
Swollen Glands		Redness	
		Itchiness	
Cardiovascular		Masses/lumps	
Swelling		Musculoskeletal	
Chest Pain		Soft tissue swelling	
Shortness of breath with activity		Muscle pain	
Heart Palpitations (heart racing or fluttering)		Moves arms and legs well	
Breasts		Localized joint pain	
Lumps		Previous injuries	
Tenderness		Spine pain	
Discharge		Pain radiating down arms	
		Pain radiating down legs	
		Weakness in arms	
		Weakness in legs	

## Pediatric Medical Health History Form

Skin		Female Health	
	Pain		Irregular Menses
	Itching		Non-menstrual Bleeding
	Dryness/Flaking		Menopausal Symptoms
	Redness		Hot Flashes
	Rash/Hives		Night Sweats
	Growths/Lumps		Dry Vaginal Mucosa
	Swelling		Change in Libido (sex drive)
	Bruising		Orgasmic Dysfunction
	Insect Bites		Difficult or Painful Intercourse
	Lesions		Vaginal Tightening
Neuro		Male Health	
	Numbness		Change in Libido
	Weakness		Difficulty with Intercourse
	Tingling		Impotence
	Burning	Allergic/Immunologic	
	Shooting Pain		Seasonal Allergies
	Headache		Sneezing
	Dizziness		Runny Nose
	Trouble finding words or forgetting words		Food Allergy
	Speech Difficulties		Contact Dermatitis (allergic skin rash)
	Poor Coordination		
	Loss of Consciousness		
	Arm or hand weakness		
	Difficulty Emptying Bladder		
	Change in Bowel Habits		
Psychiatric			
	Decreased Functioning Ability		
	Depression		
	Anxiety		
	Insomnia		
	Stress		
	Loss of Interest		

Please feel free to make any additional comments for any symptoms you are experiencing or any concerns you may have and would like to discuss at your initial appointment:

---



---



---



---



---