

Middlesex Health Primary Care

Adult New Patient Packet



Dear New Patient,

We are pleased to welcome you as a patient of Middlesex Health Primary Care. Each and every day, the people at Middlesex Health Primary Care work to provide patient-centered, compassionate care to patients throughout our communities. We're proud of the association we have with one of the top hospitals in Connecticut, and we are confident that we can provide you with the best care possible. Thank you for choosing Middlesex Health Primary Care. We look forward to managing your health.

Sincerely,

Middlesex Health Primary Care

Patient Name: _____

First Appointment Date: _____

First Appointment Location: _____

First Appointment Provider Name: _____

Forms to Complete: (We will accept and we appreciate completed forms prior to your visit)

- Form 1: Authorization to Release Health Information (Used to obtain previous records)
- Form 2: Patient Information Form
- Form 3: Consent for Treatment/Release Information/Financial/HIPAA/Photo
- Form 4: Authorization to Disclose Health Information to Family & Friends
- Form 5: Health History Questionnaire (3 pages)

Please Bring the Following to your visit:

- Medical records (Complete and return Form 1 prior to first visit)
- Insurance card
- Required Co-Pay
- Completed patient forms (All 5 Forms)
- All medications you are currently taking, in original containers

Important Reminder: Please note that chronic pain management is not a core service of primary care and will not be routinely done at Middlesex Health Primary Care. If you have any questions about this, please feel free to contact our office.

FORM 1
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient:	DOB:
------------------	------

I hereby authorize Middlesex Health Primary Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Send the Medical Records To:

Method: <input type="checkbox"/> Mail <input type="checkbox"/> Pick up <input type="checkbox"/> Fax		
Medical Group Name: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Fax: (If needed): _____		
Phone: _____		

Method: <input type="checkbox"/> Mail <input type="checkbox"/> Pick up <input type="checkbox"/> Fax		
Name: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Fax: (If needed): _____		
Phone: _____		

What is the Purpose of Health Information Release?

<input type="checkbox"/> Personal	<input type="checkbox"/> New Physician	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Medical Ins. Claim	<input type="checkbox"/> Life Insurance	
<input type="checkbox"/> Consultation	<input type="checkbox"/> Worker's Comp	<input type="checkbox"/> Attorney	

Describe the Health Information to be released:

Service Dates: from: _____ to: _____ Information Needed By: _____			
<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> History and Physical	<input type="checkbox"/> EKG's	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Hospital Notes
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Clinic Notes
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Billing Information

I understand that Middlesex Health Primary Care will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Middlesex Health Primary Care. I understand that I may not be able to revoke this Authorization if Middlesex Hospital Primary Care has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

Date:	Signature of Patient or Person granting Authorization on behalf of patient

Printed Name of Person Signing (If Not the Patient)

Relationship to Patient

FORM 1 (page 2)

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

"The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR 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." (42 C.F.R. § 2.32)

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

Demographics

Last Name:	First Name:	Middle:
Preferred Name:	Suffix:	
Address:	Mailing Address:	
City:	State:	Zip:
Date of Birth:	Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Transgender
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered		

Contact Information

Home Phone:	Cell Phone:	Work Phone:
Appointment Reminder Preference: (choose one) <input type="checkbox"/> Home or <input type="checkbox"/> Cell If Cell: <input type="checkbox"/> Voice or <input type="checkbox"/> Text		
Personal Email Address for Patient Portal Use:		
Emergency Contact Name:	Emergency Contact Phone:	
Relation to You:		

Pharmacy Preference/Insurance Information

Local Pharmacy Name:	Local Pharmacy Address:
Mail Order Pharmacy:	Mail Order Pharmacy Address:
Insurance Information: <i>Please bring your insurance card to each visit</i>	

Additional Information

Race: <input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Black-African American
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Unreported/Refused to Report	<input type="checkbox"/> Other Race
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refused to Report		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		

PRINT NAME: _____

DOB: _____

CONSENT FOR TREATMENT:

Permission is hereby given to the physicians and staff of Middlesex Health Primary Care ("MHPC"), a Middlesex Health System affiliate, to provide ordinary and necessary medical examination, diagnosis and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care as well as laboratory tests, but shall not include surgery, general anesthesia, laboratory tests for which separate consent is required under the law or other extraordinary procedures. I further consent to routine immunizations for future office visits.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Health. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

FINANCIAL AGREEMENT/ASSIGNMENT OF INSURANCE BENEFITS:

I understand that I am obligated to pay MHPC for services provided to me in accordance with the rates and terms of MHPC, including a "No-Show" fee of **\$45 for a missed office visit and \$75 for a missed comprehensive physical exam or surgical procedure appointment** if I fail to appear and did not cancel at least 24 hours in advance. In consideration for services provided or to be provided to me, I hereby assign to MHPC all basic and major medical or other insurance benefits, including, without limitation, Medicare or Medicaid benefits, to cover such expenses. In connection with such assignment, MHPC is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information (including, without limitation, copies of any plans, contract, or other documents defining or otherwise limiting the scope of insurance coverage by such carrier) as may be necessary to process any insurance claims related to my treatment by MHPC. If I am not insured, I hereby authorize MHPC to use and/or disclose my health information in order to obtain funds to cover expenses related to my treatment by MHPC. I owe and agree to pay MHPC for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by MHPC to collect the balance owed. I also authorize payment directly to MHPC or the entity providing service under the above account number that would otherwise be payable to me.

HIPAA ACKNOWLEDGEMENT:

The undersigned hereby acknowledges that I have received a copy of the Middlesex Health System Joint Notice of Privacy Policy.

CONSENT FOR PHOTO IDENTIFICATION:

I consent to MHPC taking a digital photograph of my face for purposes of patient identification. The digital photograph will remain with my electronic medical chart and will not be used for other purposes without my authorization.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

Date

Signature of Patient or Person Granting Authorization on Behalf of Patient

If the patient has not signed this form, please print the signer's name, relationship to the patient and, if necessary, explain why the patient did not sign.
CC2606 (2-20-17) 7655673v3



FORM 4: AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY & FRIENDS

Name of Patient: _____

DOB: _____

Your privacy is important to us and we want to protect it as much as possible. By signing this form, you authorize Middlesex Health Primary Care to disclose information as requested to the individual(s) below.

Name	Relationship to Patient

AUTHORIZATION FOR RELEASE OF INFORMATION:

I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Health. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

Signature of Patient or Person granting Authorization on behalf of patient

Date

Printed Name of Person Signing (If Not the Patient)

Relationship to Patient

FORM 5: MHPC – Health History Questionnaire

Name: _____ Preferred Name: _____ DOB: _____

Current Concerns: No concerns Establish care with a new Primary Care Provider

1. _____ 3. _____
 2. _____ 4. _____

Past Health History:

Have you had any of the following medical conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Acid reflux / Heartburn | <input type="checkbox"/> Gout | <input type="checkbox"/> Mobility problems |
| <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> Gynecological problems
(Explain: _____) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety / Panic attacks | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Arthritis (Location: _____) | <input type="checkbox"/> Heart disease / Heart attack | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Bone fracture
(Location: _____) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Skin condition
(Explain: _____) |
| <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> Hernia (Location: _____) | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach / GI problems
(Explain: _____) |
| <input type="checkbox"/> Chronic pain (Location: _____) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Concussion / Head injury | <input type="checkbox"/> Irregular heart beat /
Palpitations | <input type="checkbox"/> Substance or alcohol abuse |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Joint problems
(Location: _____) | <input type="checkbox"/> Transgender / Gender
nonconforming |
| <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Kidney problems
(Explain: _____) | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Dementia / Alzheimer's | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine / Frequent
headaches | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Diabetes / High blood sugar | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Erectile dysfunction | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fibromyalgia | | |
| <input type="checkbox"/> Glaucoma | | |

Have you had any of the following surgeries?

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Dilation & Curettage (D&C) | <input type="checkbox"/> Hernia repair (Location: _____) |
| <input type="checkbox"/> Back surgery (Location: _____) | <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Biopsy (Location: _____) | <input type="checkbox"/> Gallbladder removal | <input type="checkbox"/> Joint replacement(s)
(Location: _____) |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Gastric bypass / Weight loss
surgery | <input type="checkbox"/> Pacemaker insertion |
| <input type="checkbox"/> Carotid artery surgery | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Cataract surgery | <input type="checkbox"/> Heart stent(s) | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colon surgery (Type: _____) | <input type="checkbox"/> Hemorrhoid surgery | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> C-Section(s) | | |

Prior Hospitalizations: *Please include year and reason*

List Health Care providers involved in your care: *(Example Dr. Jones - Cardiology)*

Allergies: *Please include name of medication or food and type of reaction*

Name	Reaction	Name	Reaction
1)		3)	
2)		4)	

FORM 5: MHPC – Health History Questionnaire

Name: _____ DOB: _____

Current Medications: *Please include prescription medications, over-the-counter drugs, vitamins and supplements*

Name / Dose	# Tabs / Frequency	Name / Dose	# Tabs / Frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Family History: *Please indicate if any of the following conditions are present in your family members*

Relative	Status	Cancer (Specify Type)	Diabetes	Heart Disease	High Blood Pressure	Mental Illness (Specify)	Stroke	Other (ex: dementia, thyroid disease)
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Paternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Paternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Paternal Other_____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Maternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Maternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Maternal Other_____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Siblings _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Children _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Social History:

Highest level of Education: _____ Location of Birth: _____
 Occupation: _____ Occupational/Environmental Exposures: _____
 Marital status: Single Married Divorced / Separated Widowed In a relationship
 Past sexual history: *(check all that apply)* Male partners Female partners Multiple partners
 Current sexual history: *(check all that apply)* Male partners Female partners Multiple partners Not Active
 Do you feel safe with your partner? No Yes Not Applicable
 Do you feel safe at home? No Yes Who do you live with? _____
 Do you have a case manager or social worker? No Yes (provide name / phone #: _____)
 Alcohol use: None Yes (# of drinks / day: _____, # of drinks / week: _____)
 Tobacco use: Never Former (Quit Date: _____) Current (# of cigs / day: _____) E-cigs / Vape / Chew
 Recreational drugs: None History of injection drug use Past / Current use (Explain: _____)
 Diet: Diabetic Heart Healthy "Meat & Potatoes" Mediterranean Vegetarian Other_____

Name: _____

DOB: _____

Social History Continued:

- Do you exercise regularly? No Yes (What type and how often? _____)
- Have you fallen in the past year? No Yes
- Have you traveled outside the U.S. in the past 5 years? No Yes (Where? _____)
- Do you have an Advanced Directive or Living Will? No Yes (if yes, please make sure we receive a copy)
- Code status: Full Code Do Not Resuscitate Do Not Resuscitate / Do Not Intubate Unknown

Preventive Health History: Please indicate the date the following were performed

	Date		Date
Last wellness visit / Complete physical		Stress test	
Breast cancer screening (Mammogram)		Hepatitis C screening (if born 1945-1965)	
Cervical cancer screening (Pap smear, HPV test)		Flu Vaccine	
Colon cancer screening (Colonoscopy, Cologuard)		Pneumonia Vaccine	
Lung cancer screening (CT scan for high risk only)		Shingles Vaccine	
Osteoporosis screening (Bone density)		Tetanus / TDAP Vaccine	

Review of Systems: Please check the box if you have experienced any of the following symptoms in the **past 4 weeks**

GENERAL

- Weight gain or loss over 10 pounds
- More fatigue than usual
- Fever, chills, or night sweats.....

SKIN

- Changes in your skin, hair, or nails
- Dryness or itching
- Rashes.....
- Jaundice or yellowing of the skin.....
- Moles that have changed in appearance.....

HEAD

- Headaches
- Head injuries.....

EYES

- Trouble with your vision
- Eyeglasses/contact lenses
- Eye pain, redness, or excessive tearing
- Double vision

EARS

- Trouble with hearing
- Pain in ear
- Discharge (fluid) from ear.....
- Ringing in ears
- Spinning or vertigo attacks

NOSE/SINUSES

- Face or sinus pressure
- Postnasal drip
- Nasal congestion
- Nosebleeds

MOUTH/THROAT

- Recent change in taste
- Bleeding of gums, mouth, or throat
- Sore throat or hoarse voice

NECK

- Swollen glands or lumps
- Neck pain or stiffness

BREAST

- Breast lumps or bumps.....
- Discharge from the nipple
- Pain in the breast.....

CARDIOVASCULAR

- Swelling in legs or feet.....
- Difficult or uncomfortable breathing
- Needing to sleep upright to breathe better
- Chest pain, pressure, or tightness
- Racing, pounding, or irregular heart beat ...

RESPIRATORY

- Wheezing.....
- Chronic or frequent cough
- Coughing up phlegm (mucus).....
- Coughing up blood
- Exposure to someone with Tuberculosis.....

GASTROINTESTINAL

- Trouble/pain with swallowing
- Frequent Heartburn
- Pain after eating
- Abdominal pain/discomfort
- Nausea/vomiting
- Vomiting up blood
- Changes in bowel habits.....
- Constipation
- Diarrhea.....
- Unusual colored stools
- Bleeding from rectum

GENITOURINARY

- Difficulty passing urine
- Frequent urination
- Urinating more than once at night.....
- Any pain, burning, or odor to urine.....
- Leak urine or wet yourself.....
- Urine appeared bloody or reddish
- Groin pain / bulge with lifting or straining ..

REPRODUCTIVE

- Sores on or discharge from the penis.....
- Lump on the testicle.....
- Pain in the testicles
- Sores on or discharge from the vagina.....
- Menstrual cycle irregularities.....
- Unexpected vaginal bleeding
- Vaginal pain, dryness, itchiness, or odor.....

SEXUAL HEALTH

- Interested in getting pregnant
- Not using any contraception
- Concern for sexually transmitted infection.
- Problems/concerns about sexual function .
- Had an unwanted sexual experience

PERIPHERAL VASCULAR

- Pain or numbness in legs while walking
- Fingertips change color when cold.....
- Varicose Veins

MUSCULOSKELETAL

- Joint pain
- Swelling, redness, or warmth in joints
- Back pain or stiffness
- Weakness in muscle(s)

NEUROLOGICAL

- Dizzy spells or lightheadedness.....
- Convulsions or seizures
- Loss of consciousness/ fainting.....
- Any speech problems
- Trouble staying awake
- Problems with memory
- Numbness or tingling in hands or feet
- Weakness in particular part of body
- Trouble with sleep

HEMATOLOGICAL

- Bleed or bruise easily
- Received any blood transfusions.....

ENDOCRINE

- Do you ever feel too hot or too cold
- Excessive thirst

BEHAVIORAL HEALTH

- Seen a counselor, therapist, or psychiatrist
- Experience mood swings.....
- Feel depressed
- Loss of interest or pleasure in things
- Thoughts of self harm or suicide.....
- Previous suicide attempt.....
- Feel frequently worried or nervous
- Feel you should cut down on drinking