

# Middlesex Health Primary Care Pediatric 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 for the safety of our patients Middlesex Health Primary Care will not accept new pediatric patients who do not obtain routine vaccinations (including measles, mumps, rubella, varicella, poliomyelitis, pneumococcus, and haemophilus influenzae type b). If you have any questions about this policy, please feel free to contact our office.

**FORM 1**  
**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

Name of Patient: _____	DOB: _____
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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: Middlesex Health Primary Care
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:	Date of Birth:
Address:	Mailing Address:	
City:	State:	Zip:
Legal Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	<input type="checkbox"/> Nonbinary	<input type="checkbox"/> X
Sex Assigned at Birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	<input type="checkbox"/> Unknown	
Gender Identify: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female (M to F) <input type="checkbox"/> Transgender Male (F to M) <input type="checkbox"/> Other		
Preferred Pronouns: <input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/them/theirs <input type="checkbox"/> Preferred Name (as above) <input type="checkbox"/> Decline to answer		
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 / Lab Preference/Insurance Information**

Local Pharmacy Name:	Local Pharmacy Address:
Mail Order Pharmacy:	Mail Order Pharmacy Address:
Preferred Lab:	
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:	
Employer:	Occupation:

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

**Notification of Disclosures to Persons Involved in Your Care**

(This form may be used for all other hospital services and Off-site Locations.)

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Permission to disclose information by telephone or by mail:**

No, I do not wish to have information via phone message or written communication.

Yes, I wish to be contacted in the following manner:

<b>Home #:</b>  <input type="checkbox"/> Leave a message with detailed information <input type="checkbox"/> Leave a message with the call-back number only	<b>Work #:</b>  <input type="checkbox"/> Leave a message with detailed information <input type="checkbox"/> Leave a message with the call-back number only	<b>Cellphone #:</b>  <input type="checkbox"/> Leave a message with detailed information <input type="checkbox"/> Leave a message with the call-back number only
<input type="checkbox"/> <b>Written Communication</b> <input type="checkbox"/> Mail to my home address: _____ <input type="checkbox"/> Mail to my work/office address: _____ <input type="checkbox"/> Fax to this number: _____		

Other: \_\_\_\_\_

**Permission to disclose information to family or other persons involved in your care**

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about a prescription, bill, schedule appointments or otherwise discuss your care or treatment with anyone other than you.

No, I do not wish to have information shared with family or other persons involved in my care.

Yes, I would like MHS to be able to discuss information related to my care with specific persons, listed below:

Name	Phone number	Relationship to Patient

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Relationship to Patient

# FORM 5: MHPC – Pediatric Health History Questionnaire

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_

**Past Health History:**

*Have you had any of the following medical conditions?*

- |                                                             |                                                                         |                                                                    |
|-------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Acid reflux / Heartburn            | <input type="checkbox"/> Eczema                                         | <input type="checkbox"/> Migraines / Headaches                     |
| <input type="checkbox"/> ADD / ADHD                         | <input type="checkbox"/> Feeding difficulties                           | <input type="checkbox"/> Poor weight gain                          |
| <input type="checkbox"/> Anemia (low blood count)           | <input type="checkbox"/> Food allergy / Intolerance<br>(Explain: _____) | <input type="checkbox"/> Premature birth                           |
| <input type="checkbox"/> Anxiety / Panic attacks            | <input type="checkbox"/> Gynecological problems<br>(Explain: _____)     | <input type="checkbox"/> Scoliosis                                 |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Hearing loss                                   | <input type="checkbox"/> Seasonal allergies                        |
| <input type="checkbox"/> Autism Spectrum Disorder           | <input type="checkbox"/> Heart murmur                                   | <input type="checkbox"/> Seizures                                  |
| <input type="checkbox"/> Bed wetting                        | <input type="checkbox"/> High blood pressure                            | <input type="checkbox"/> Sexually transmitted infection            |
| <input type="checkbox"/> Blood clotting disorder            | <input type="checkbox"/> High cholesterol                               | <input type="checkbox"/> Skin condition<br>(Explain: _____)        |
| <input type="checkbox"/> Bone fracture<br>(Location: _____) | <input type="checkbox"/> Irregular heart beat /<br>Palpitations         | <input type="checkbox"/> Sleep apnea                               |
| <input type="checkbox"/> Cancer (Type: _____)               | <input type="checkbox"/> Jaundice                                       | <input type="checkbox"/> Stomach / GI problems<br>(Explain: _____) |
| <input type="checkbox"/> Concussion / Head injury           | <input type="checkbox"/> Joint problems<br>(Explain: _____)             | <input type="checkbox"/> Substance or alcohol abuse                |
| <input type="checkbox"/> Constipation                       | <input type="checkbox"/> Kidney problems                                | <input type="checkbox"/> Transgender/ Gender<br>nonconforming      |
| <input type="checkbox"/> Cystic Fibrosis                    | <input type="checkbox"/> Lead exposure                                  | <input type="checkbox"/> Thyroid problems                          |
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Learning disorder                              | <input type="checkbox"/> Urinary tract infections                  |
| <input type="checkbox"/> Developmental Delay: Motor         | <input type="checkbox"/> Liver problems                                 | <input type="checkbox"/> Other: _____                              |
| <input type="checkbox"/> Developmental Delay: Speech        |                                                                         | <input type="checkbox"/> Other: _____                              |
| <input type="checkbox"/> Diabetes / High blood sugar        |                                                                         |                                                                    |
| <input type="checkbox"/> Ear infections                     |                                                                         |                                                                    |

*Have you had any of the following surgeries?*

- |                                                   |                                       |                                                          |
|---------------------------------------------------|---------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Appendectomy             | <input type="checkbox"/> Circumcision | <input type="checkbox"/> Hernia repair (Location: _____) |
| <input type="checkbox"/> Biopsy (Location: _____) | <input type="checkbox"/> Ear tubes    | <input type="checkbox"/> Tonsillectomy                   |
|                                                   |                                       | <input type="checkbox"/> Other: _____                    |

**Birth and Developmental History:**

Type of birth (please check):     Vaginal     C-Section    Location of birth: \_\_\_\_\_

Born within 3 weeks of due date?     Yes     No    If no, at how many weeks? \_\_\_\_\_

Birth weight: \_\_\_\_\_    Birth length: \_\_\_\_\_    Breastfed:     Yes     No

List any complications with pregnancy, delivery, or during newborn period: \_\_\_\_\_

**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 – Pediatric 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)		3)	
2)		4)	

**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: ADHD, early or unexpected death)
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"/>	

**Social History:**

Who lives in the child's home? \_\_\_\_\_ Primary caretaker(s): \_\_\_\_\_

Grade level / School: \_\_\_\_\_ 504B / IEP Education Plan:  No  Yes

Extracurricular activities / Sports: \_\_\_\_\_

Interests / hobbies: \_\_\_\_\_ Job: \_\_\_\_\_

Parent or Caregiver smokes?  No  Yes

Tobacco use:  Never  Former Smoker  Current Smoker (# cigs / day: \_\_\_\_\_)  E-cigs / Vape / Chew

Alcohol use:  Never  Tried in the past  Current use (# drinks/ week: \_\_\_\_\_)

Recreational drugs:  Never  Tried in the past  Current use (What and how often? \_\_\_\_\_)

Do you exercise regularly?  No  Yes (What type and how often? \_\_\_\_\_)

Diet (please check all that apply):  Healthy  Vegetarian  Junk/Fast food  Other \_\_\_\_\_

Environmental Exposures: \_\_\_\_\_

Have you traveled outside the country in the past 5 years?  No  Yes (Where? \_\_\_\_\_)

Do you feel safe at home and in your neighborhood:  Yes  No (Explain: \_\_\_\_\_)

Concerns for bullying?  No  Yes (Explain: \_\_\_\_\_)

Involved with Birth to Three:  No  Yes (Explain: \_\_\_\_\_)

Involved with WIC:  No  Yes Involved with DCF:  No  Yes



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Safety / Injury Prevention:** Please indicate if you routinely use or have the following

Safety Measure	Yes	No	Not applicable
Seat belts	<input type="checkbox"/>	<input type="checkbox"/>	
Bike helmet	<input type="checkbox"/>	<input type="checkbox"/>	
Sunscreen	<input type="checkbox"/>	<input type="checkbox"/>	
Smoke detectors	<input type="checkbox"/>	<input type="checkbox"/>	
Carbon monoxide detectors	<input type="checkbox"/>	<input type="checkbox"/>	
Fire extinguisher	<input type="checkbox"/>	<input type="checkbox"/>	
Stair gates / cabinet locks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gated pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guns safely secured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**GENERAL**

- Excessive weight gain .....
- Lost over 10 pounds .....
- Fever, chills, night sweats .....

**SKIN**

- Rashes .....
- Moles that have changed in appearance ....

**EYES**

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

**EARS**

- Trouble with hearing .....
- Pain in ear .....
- Discharge (fluid) from ear .....

**NOSE/SINUSES**

- Trouble with nose/sinuses .....
- Nosebleeds .....

**MOUTH/THROAT**

- Sore throat .....
- Hoarse voice .....

**NECK**

- Swollen glands or lumps .....
- Neck pain or stiffness .....

**BREAST**

- Breast lumps or bumps .....
- Pain in the breast .....

**CARDIOVASCULAR**

- Chest pain .....
- Racing, pounding heart beat .....
- Irregular heart beat .....

**RESPIRATORY**

- Wheezing .....
- Coughing/ Nighttime coughing .....
- Exposure to someone with Tuberculosis .....

**GASTROINTESTINAL**

- Abdominal pain/belly pain .....
- Nausea/vomiting .....

- Changes in bowel habits .....
- Constipation .....
- Diarrhea .....

**GENITOURINARY**

- Frequent urination .....
- Any pain or burning with urinating .....

**MUSCULOSKELETAL**

- Pain in your joints .....
- Swelling, redness, or warmth in joints .....
- Back or shoulder pain .....

**NEUROLOGICAL**

- Dizzy spells or lightheadedness .....
- Any fainting spells .....
- Frequent headaches .....

**HEMATOLOGICAL**

- Bleed or bruise easily .....

**ENDOCRINE**

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

**PSYCHIATRIC**

- Seen a counselor/therapist or psychiatrist ..
- Experience mood swings .....
- Feel depressed .....
- Feel a loss of interest in life .....
- Feel frequently worried or nervous .....

**SEXUAL HEALTH**

- Sexually active .....
- More than one sexual partner .....
- Not using any contraception .....
- Worried about sexually transmitted infections .....
- Had an unwanted sexual experience .....

**REPRODUCTIVE**

- Lump on the testicle .....
- Pain in the testicles .....
- Menstrual cycle irregularities .....
- Unusual vaginal discharge or odor .....

Reviewed by Primary Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_