

# FEMINIST WOMEN'S HEALTH CENTER

## CONSENT FOR WELLNESS SERVICES

**Please read and sign below if you have an appointment with the nurse practitioner today:**

I consent to care and treatment at the Feminist Women's Health Center. I understand that I will be seen by a nurse practitioner. I also understand that all or part of my accessory health services will be provided by trained healthworkers.

If the nurse practitioner finds anything beyond the scope of her practice and/or experience during my examination, I understand that I may be referred to a physician or other facility. I understand that the nurse practitioner may consult with a collaborating physician by telephone. I understand that if my situation warrants a referral to another health care provider, I shall be solely responsible for making those arrangements and for any fees associated with the healthcare I receive.

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Client Signature

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Date

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Staff Signature

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Date

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## CONSENT FOR LABORATORY SERVICES

**Please read and sign below if you do not have an appointment with the nurse practitioner today and will be receiving laboratory testing:**

I consent to laboratory testing at the Feminist Women's Health Center. I understand that the interpretation of any laboratory test results should be made only by a licensed health care provider as factors unclear to the lay person may exist.

Because the implications of laboratory testing results can be complex, involving medical, emotional, and social issues, some results will only be reported to the client in person and so will require a follow up visit. My laboratory test results and patient information are confidential and may only be released to me. I will need to sign a request for release of medical records if I want my results mailed or faxed to another health care provider.

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Client Signature

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Date

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Staff Signature

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Date

## **Feminist Women's Health Center Patient Privacy Notice Authorization**

In order to comply with new federal guidelines outlined in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), a Federal law which seeks to protect the privacy of consumers' healthcare information, we are advising you of your right as to how your medical information may be used.

The *NOTICE OF PRIVACY PRACTICES* located in the waiting rooms of the clinic outlines how personal information about you may be used and how you can get access to this information. If you would like a paper copy of the *NOTICE OF PRIVACY PRACTICES* please ask and we will be glad to provide you with one.

I have also been informed that any payment I make today is part of a global fee structure, which means that it is a discounted fee. Therefore, I may not file insurance at any time for reimbursement in relation to services I receive today. Furthermore, I understand and agree that the receipt for my payment today does not include an itemized statement and that the Feminist Women's Health Center is not obligated to issue itemized statements for services rendered.

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I authorize the Feminist Women's Health Center to communicate medical information pertaining to my care by the methods outlined in the *NOTICE OF PRIVACY PRACTICES*. I am aware that I may ask for a paper copy of the *NOTICE OF PRIVACY PRACTICES* at any time.

Client signature \_\_\_\_\_

Witness \_\_\_\_\_

# Feminist Women's Health Center

## Request for Information

### 1. Please indicate your race:

- |  |   |
|--|---|
| <input type="checkbox"/> Asian Pacific Islander      | <input type="checkbox"/> Multi-Racial (Other)           |
| <input type="checkbox"/> Asian/Asian American        | <input type="checkbox"/> Multi-Racial (Person of Color) |
| <input type="checkbox"/> Bi-Racial (Other)           | <input type="checkbox"/> Native American                |
| <input type="checkbox"/> Bi-Racial (Person of Color) | <input type="checkbox"/> White/Caucasian                |
| <input type="checkbox"/> Black/African American      | <input type="checkbox"/> Other/Unknown                  |
| <input type="checkbox"/> Hispanic/Latino             |   |

### 2. Please indicate your primary language:

- |                                    |                                   |                                     |                                     |
|------------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Arabic    | <input type="checkbox"/> French   | <input type="checkbox"/> Mixtec     | <input type="checkbox"/> Spanish    |
| <input type="checkbox"/> Bosnian   | <input type="checkbox"/> German   | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cakchikel | <input type="checkbox"/> Hindi    | <input type="checkbox"/> Punjabi    | <input type="checkbox"/> Zapotec    |
| <input type="checkbox"/> Chinese   | <input type="checkbox"/> Japanese | <input type="checkbox"/> Quiche'    | <input type="checkbox"/> Other      |
| <input type="checkbox"/> English   | <input type="checkbox"/> Korean   | <input type="checkbox"/> Russian    |                                     |

### 3. Please indicate your religion:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Agnostic         | <input type="checkbox"/> Episcopalian              | <input type="checkbox"/> Mormon/Latter Day Saints |
| <input type="checkbox"/> Atheist          | <input type="checkbox"/> Evangelist/Fundamentalist | <input type="checkbox"/> Muslim                   |
| <input type="checkbox"/> Baptist          | <input type="checkbox"/> Hindu                     | <input type="checkbox"/> Presbyterian             |
| <input type="checkbox"/> Buddhist         | <input type="checkbox"/> Jehovah's Witness         | <input type="checkbox"/> Quaker                   |
| <input type="checkbox"/> Catholic         | <input type="checkbox"/> Jewish                    | <input type="checkbox"/> Unitarian                |
| <input type="checkbox"/> Christian        | <input type="checkbox"/> Lutheran                  | <input type="checkbox"/> Wiccan                   |
| <input type="checkbox"/> Church of Christ | <input type="checkbox"/> Methodist                 | <input type="checkbox"/> Other                    |

### 4. Please indicate any temporary or permanent physical challenges you may have:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> None               | <input type="checkbox"/> Deaf                    | <input type="checkbox"/> Mute           |
| <input type="checkbox"/> Blind              | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Non-Ambulatory |
| <input type="checkbox"/> Breathing Impaired | <input type="checkbox"/> Multiple Disabilities   | <input type="checkbox"/> Other          |

### 5. Please indicate your relationship status:

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Partnered         |
| <input type="checkbox"/> Widowed  | <input type="checkbox"/> Legally Separated |
| <input type="checkbox"/> Married  | <input type="checkbox"/> Single            |

### 6. Please indicate your national origin:

- |   |   |
|---|---|
| <input type="checkbox"/> African (Any Country)        | <input type="checkbox"/> Korean                       |
| <input type="checkbox"/> American                     | <input type="checkbox"/> Mexican                      |
| <input type="checkbox"/> Asian (Country Not Listed)   | <input type="checkbox"/> Middle Eastern (Any Country) |
| <input type="checkbox"/> Bosnian                      | <input type="checkbox"/> Native American              |
| <input type="checkbox"/> Brazilian                    | <input type="checkbox"/> Puerto Rican                 |
| <input type="checkbox"/> Caribbean (Non-Puerto Rican) | <input type="checkbox"/> Russian                      |
| <input type="checkbox"/> Columbian                    | <input type="checkbox"/> Salvadorian                  |
| <input type="checkbox"/> Guatemalan                   | <input type="checkbox"/> Vietnamese                   |
| <input type="checkbox"/> Indian                       | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Japanese                     |   |

**7. Please indicate the combined annual income level for your entire household:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Less than \$12,250  | <input type="checkbox"/> \$29,251 - \$33,500 | <input type="checkbox"/> \$75,001 - \$100,000   |
| <input type="checkbox"/> \$12,251 - \$15,500 | <input type="checkbox"/> \$33,501 - \$37,750 | <input type="checkbox"/> \$100,001 - \$150,000  |
| <input type="checkbox"/> \$15,501 - \$20,750 | <input type="checkbox"/> \$37,751 - \$42,000 | <input type="checkbox"/> \$150,001 - \$200,000  |
| <input type="checkbox"/> \$20,751 - \$25,000 | <input type="checkbox"/> \$42,001 - \$50,000 | <input type="checkbox"/> \$200,001 - \$250,000  |
| <input type="checkbox"/> \$25,001 - \$29,250 | <input type="checkbox"/> \$50,001 - \$75,000 | <input type="checkbox"/> Greater than \$250,000 |

**8. Please indicate your sexual orientation:**

- |                                       |                                      |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bisexual     | <input type="checkbox"/> Pansexual   |
| <input type="checkbox"/> Gay          | <input type="checkbox"/> Queer       |
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Questioning |
| <input type="checkbox"/> Lesbian      | <input type="checkbox"/> Other       |

**9. Please indicate the number of family members in your household, including yourself:**

- |                            |                            |                            |                                       |
|----------------------------|----------------------------|----------------------------|---------------------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 4 | <input type="checkbox"/> 7 | <input type="checkbox"/> 10           |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 5 | <input type="checkbox"/> 8 | <input type="checkbox"/> More than 10 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 6 | <input type="checkbox"/> 9 |                                       |

**10. Please indicate your level of education:**

- |  |   |
|--|---|
| <input type="checkbox"/> Currently in Middle/High School | <input type="checkbox"/> Two Year Undergraduate Degree  |
| <input type="checkbox"/> Did Not Graduate High School    | <input type="checkbox"/> Four Year Undergraduate Degree |
| <input type="checkbox"/> High School Graduate/GED        | <input type="checkbox"/> Post Graduate Degree           |

**Please indicate how you found out about the Feminist Women's Health Center:**

- |   |   |
|---|---|
| <input type="checkbox"/> Abortion Clinic Directory (online) | Location: _____                                       |
| <input type="checkbox"/> Abortion Clinics Online            |   |
| <input type="checkbox"/> Atlanta Latino                     |   |
| <input type="checkbox"/> Been Here Before                   |   |
| <input type="checkbox"/> Billboard                          |   |
| <input type="checkbox"/> Community Organization             | <input type="checkbox"/> Refugee Family Services      |
| <input type="checkbox"/> Creative Loafing                   | <input type="checkbox"/> Refugee Women's Network      |
| <input type="checkbox"/> Dekalb Rape Crisis Center          | <input type="checkbox"/> Southern Voice               |
| <input type="checkbox"/> Discount Coupon                    | <input type="checkbox"/> Tapestri                     |
| <input type="checkbox"/> Friend                             | <input type="checkbox"/> Website (FWHC)               |
| <input type="checkbox"/> Gay Yellow Pages                   | <input type="checkbox"/> Yellow Pages                 |
| <input type="checkbox"/> Health Department                  | <input type="checkbox"/> Other Internet Ads/Listing   |
| <input type="checkbox"/> Health Fair/Table                  | <input type="checkbox"/> Other: Please Specify: _____ |
| <input type="checkbox"/> In-Site Magazine                   |   |
| <input type="checkbox"/> Insurance Provider                 |   |
| <input type="checkbox"/> International Rescue Committee     |   |
| <input type="checkbox"/> Mental Health Professional         |   |
| Name: _____   |   |
| Location: _____   |   |
| <input type="checkbox"/> NAF Hotline                        |   |
| <input type="checkbox"/> Physician                          |   |
| Name: _____   |   |

FEMINIST WOMEN'S HEALTH CENTER

Please complete all information up to solid line

Today's Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Allergies: \_\_\_\_\_ Pharmacy Name/ Number: \_\_\_\_\_

Purpose of Visit: (Please circle numbers of ALL that apply:)

- 1. Vaginal infection or pelvic pain 2. Screening for STI's 3. Bladder infection 4. Breast check
5. Pap Smear 6. Post-abortion care/concerns 7. Birth Control 8. Other: \_\_\_\_\_

The following information will help us in making decisions about your care today:

Are you sexually active now Yes/No If applicable: Number of partners:\_\_\_ Are they male/female/both
Partner(s) have an infection Yes/No Length of time with current partner: \_\_\_\_\_mth/yr.
1st day of last normal period:\_\_\_\_\_ Birth Control used: Yes/No/NA Everytime?: Yes/No
Current Method of Birth control:\_\_\_\_\_ Used this for how long?:\_\_\_\_\_ Problems:\_\_\_\_\_
Are you currently breastfeeding Yes/No Any changes in your medical history since last visit Yes/No
Explain:\_\_\_\_\_

List any current medications (over the counter or prescription) or herbs: \_\_\_\_\_

OFFICE USE ONLY

Lab: as applicable: Temp:\_\_\_\_\_ Resp:\_\_\_\_\_ B/P:\_\_\_/\_\_\_ Pulse:\_\_\_\_\_ HCT:\_\_\_\_\_ Ht:\_\_\_\_\_ Wt:\_\_\_\_\_

UA: (L/N/P/G) \_\_\_/\_\_\_/\_\_\_/\_\_\_ Other:\_\_\_\_\_

Pregnancy slide test: POS(+)/ NEG(-) Test pack: POS(+)/ NEG(-)

Comments:\_\_\_\_\_ Initials:\_\_\_\_\_

EXAMINATION:

Table with 3 columns: (WNL), (Other/Deferred), and Description/Diagram. Rows include: Thyroid, Lungs, Heart, Breast, Abdomen, Skin, Vulva, Vagina, Cervix, Uterus, Adnexa, Rectal, Discharge, Other.

Pap: Yes/No Cultures: Yes/No GC/ Chlamydia/ Herpes/ Other:\_\_\_\_\_

Wet Prep: Yes/No WNL Yeast; Clue; Whiff; Trich; WBC's: #\_\_\_/hpf

Assessment: \_\_\_\_\_ Plan: \_\_\_\_\_

RNC/CNM/MD: \_\_\_\_\_

FEMINIST \_\_\_\_\_ Date:\_\_\_\_\_ Time:\_\_\_\_\_

**FEMINIST WOMEN'S HEALTH CENTER  
MEDICAL HISTORY**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Legal Name \_\_\_\_\_ Preferred Pronoun (he/she/ze) \_\_\_\_\_  
Preferred Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_ Phone (h) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
City \_\_\_\_\_ Within City Limits: Yes ( ) No ( ) (w) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ (c) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
At what phone # may we contact you? \_\_\_\_\_ May we leave a message: Yes ( ) No ( )  
Emergency contact: Name \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_ Phone (h) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ (w) (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
Years of Education: \_\_\_\_\_ Language you speak: English, Spanish, French, Other \_\_\_\_\_  
Can you read/understand English to fill out this form: Yes ( ) No ( )  
If not English speaking, Interpreter's name \_\_\_\_\_  
Pharmacy # \_\_\_\_\_ Religion \_\_\_\_\_  
DRUG ALLERGIES: \_\_\_\_\_ FOOD ALLERGIES: \_\_\_\_\_  
CURRENT MEDICATIONS: \_\_\_\_\_

Use a check mark when applicable to answer questions 1 and 2:

**Contraceptive History (Birth Control):**

1. \_\_\_ Check if you DO NOT need/want birth control method/information. Skip to # 7.
2. \_\_\_ Check if this is a non-abortion visit and you are having intercourse/ risk for pregnancy
3. Current method of birth control used: \_\_\_\_\_
4. How long using this method; \_\_\_\_\_ Problems: Yes ( ) No ( )  
Describe: \_\_\_\_\_
5. **What method do you want to use now?** \_\_\_\_\_
6. Methods used in past: (circle): Pills / Patch / Ring / Shot / Norplant / IUD / condoms / cervical cap / diaphragm / foam / gel / sponge / abstinence / withdrawal / sterilization / tubes tied / vasectomy / rhythm / Natural Family Planning / Emergency Contraception / other \_\_\_\_\_

**Sexual History/ Information:** this information helps us with your care:

7. Age of first sexual experience \_\_\_ Currently in sexual relationship: Yes ( ) No ( )  
Partner(s): men / women / both now ( ) always ( )  
Do you have more than one partner? Yes ( ) No ( )  
# partners in last year: \_\_\_ Do you practice safe sex Yes ( ) No ( )  
Need information on safe sex Yes ( ) No ( )  
Recent change in partner Yes ( ) No ( )  
Do you have (circle): vaginal / oral / anal sex  
**Partners History** (circle all that apply):  
Has other partners, is bisexual  
is a hemophiliac, is HIV+/AIDS  
uses street drugs

**Social History:**

Answer yes or no to the following indicating your recent experience:

8. \_\_\_ Death of family member/friend
9. \_\_\_ Emotional/relationship problems
10. \_\_\_ Job loss/financial problems
11. \_\_\_ Problems in living arrangements/schools
12. \_\_\_ Legal problems/arrests/divorce
13. \_\_\_ Parental problems
14. \_\_\_ Has anyone forced you to have sex
15. \_\_\_ Are you afraid of your partner/family member
16. \_\_\_ Do you smoke? How many cigarettes/day \_\_\_\_\_
17. \_\_\_ Do you drink? How much alcohol do you drink per week \_\_\_\_\_
18. \_\_\_ Do alcohol/drugs cause problems in your life?
19. \_\_\_ Have you ever abused alcohol? Yes ( ) No ( ) Drugs? Yes ( ) No ( )
20. \_\_\_ Emotional/ mental illness? Anti-Depressive, anxiety or psychotic medications
21. \_\_\_ Feel you are in an abusive relationship
22. \_\_\_ As a child did anyone touch your private body parts or ask you to touch theirs
23. \_\_\_ Do you have any piercings in your mouth

**Comments - Staff Only**

**Comments - Staff Only**

- 24. \_\_\_ Do you feel you need to speak to a counselor of any kind
- 25. \_\_\_ Do you use street drugs  
What kind? \_\_\_\_\_ Last date of use \_\_\_\_\_
- 26. Who helps and supports you with your problems \_\_\_\_\_
- 27. Who do you live with \_\_\_\_\_

**OB History:**

Complete below:

- 28. Total No. Pregnancies including current: \_\_\_\_\_ Living children: \_\_\_\_\_  
Live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_  
Ectopic/tubal: \_\_\_\_\_ Other: \_\_\_\_\_  
# of C-sections: \_\_\_\_\_ Last pregnancy when: \_\_\_\_\_  
Problems with pregnancies: (high blood pressure, seizures, toxemia, gestational diabetes, birth defects) other: \_\_\_\_\_
- 29. **Are you Rh neg: Yes ( ) No ( ) Received Rhogam: Yes ( ) No ( )**
- 30. \_\_\_ Trouble getting pregnant/staying pregnant
- 31. \_\_\_ Used fertility treatments/medications
- 32. \_\_\_ Had artificial insemination (s)

**Personal Medical History:**

Answer yes or no to the following and circle items that apply: (Current & Past)

- 33. \_\_\_ Eye/vision problems, glasses/contacts
- 34. \_\_\_ Deaf/Mute. Do you know sign language Yes ( ) No ( )
- 35. \_\_\_ Heart problems/palpitations/murmurs/surgery/MVP (Mitral Valve Prolapse)
- 36. \_\_\_ High Blood Pressure
- 37. \_\_\_ Strokes/Blood Clots in head, heart, brain/Head injury
- 38. \_\_\_ Varicose veins
- 39. \_\_\_ High cholesterol/ blood fats
- 40. \_\_\_ Diabetes/High Sugar: (insulin/diet /oral/) Only with pregnancy
- 41. \_\_\_ Bladder/Kidney problems/infections
- 42. \_\_\_ Headaches/migraine, stress related or other
- 43. \_\_\_ Seizures/epilepsy: Date of last seizure \_\_\_\_\_
- 44. \_\_\_ Thyroid conditions/ medications
- 45. \_\_\_ Liver disease/Hepatitis
- 46. \_\_\_ Stomach problems/gastritis/ ulcers/reflux disease
- 47. \_\_\_ Bowel problems/Colitis/Irritable bowel/Crohns
- 48. \_\_\_ Lung Problems/Disease/Asthma=(circle one) Childhood, Seasonal; Chronic
- 49. \_\_\_ Anemia/Low Iron/Sickle Cell/Thalassemias/Blood diseases/Lupus
- 50. \_\_\_ Gallbladder disease/Surgery
- 51. \_\_\_ Cancer
- 52. \_\_\_ Numbness in legs or arms
- 53. \_\_\_ Are you currently under care for a problem/illness by a health care professional? Explain \_\_\_\_\_
- 54. \_\_\_ Have you ever been hospitalized (except childbirth):  
Explain \_\_\_\_\_
- 55. \_\_\_ Received blood products before 1978
- 56. \_\_\_ Do you faint with needles/finger sticks/pap smears
- 57. \_\_\_ Ever react to ANY DRUG/MEDICATION/FOOD: including (circle):  
barbiturates, anesthesia, shellfish, eggs, soy, Iodine, metals, latex \_\_\_\_\_
- 58. \_\_\_ Have you ever been put to sleep for any surgery? Did you have any problems-Y, N
- 59. \_\_\_ Immunizations up to date: Last tetanus: \_\_\_\_\_  
Rubella vaccination: Yes ( ) No ( ) Hepatitis B: Yes ( ) No ( )
- 60. \_\_\_ Do you use herbs/vitamins/complimentary therapies

**GYN History:**

Answer yes or no to the following:

- 61. \_\_\_ Have you ever had a pelvic exam? Date of last exam \_\_\_\_\_
- 62. \_\_\_ Breast disease or surgery
- 63. \_\_\_ Breast/nipple discharge/leaking
- 64. \_\_\_ Are you breast feeding/nursing
- 65. \_\_\_ Mammogram
- 66. \_\_\_ Vaginal infections/itching /burning
- 67. \_\_\_ Vaginal pain/bumps/swelling/sores
- 68. \_\_\_ Sexually transmitted infections (circle all that apply):  
Herpes, HPV, Chlamydia, Gonorrhea, Trichomonas, Syphilis,  
HIV, Hepatitis B, Group B Streptococcal Infection
- 69. \_\_\_ Pelvic inflammatory disease (PID) Date \_\_\_\_\_  
Treatment: \_\_\_\_\_
- 70. \_\_\_ Endometriosis/Uterine fibroids
- 71. \_\_\_ Cysts on ovaries
- 72. \_\_\_ Abnormal Pap (date) \_\_\_\_\_  
Treatment: Repeat pap (date) \_\_\_\_\_  
Colpo/Cryo/LEEP/Laser
- 73. \_\_\_ Genital circumcision
- 74. \_\_\_ Bleeding and/or pain with sex
- 75. \_\_\_ Did your mother take medications to prevent miscarriage  
when pregnant with you? DES ( ) other ( )

**Menstrual History:**

- 76. Age period began \_\_\_\_\_  
Are your cycles/periods regular? Yes ( ) No ( ) Sometimes ( )  
# days in each cycle: \_\_\_\_\_ # days you bleed: \_\_\_\_\_  
Use pads / tampons / other \_\_\_\_\_ # used on heaviest day(s) \_\_\_\_\_
- 77. \_\_\_ Cramps/pain/bloating/depression
- 78. \_\_\_ Do you use medications/herbs/other \_\_\_\_\_ for relief
- 79. \_\_\_ Bleed between periods
- 80. \_\_\_ Menopausal/Peri menopausal
- 81. First day of last period \_\_\_\_/\_\_\_\_/\_\_\_\_ Normal ( ) Abnormal ( )

**Family History:**

**Adopted: Yes ( ) No ( )**

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles

- 82. \_\_\_ Diabetes \_\_\_\_\_
- 83. \_\_\_ Heart attack before age 50 \_\_\_\_\_
- 84. \_\_\_ High Blood Pressure \_\_\_\_\_
- 85. \_\_\_ Cancer (breast, ovarian, uterus) \_\_\_\_\_
- 86. \_\_\_ Osteoporosis \_\_\_\_\_
- 87. \_\_\_ High cholesterol \_\_\_\_\_
- 88. \_\_\_ Alcoholism/addictions/mental illness \_\_\_\_\_
- 89. \_\_\_ Problems with General Anesthesia \_\_\_\_\_
- 90. \_\_\_ Birth defects/genetic illness \_\_\_\_\_

• I affirm that all of the medical information stated above is true and that I have not had anything to eat, drink or gum since \_\_\_\_\_

And that I do not have any valuables with me at this time. Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

Client signature \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_

Counselor signature \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_

RN Pre-op Signature \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_

MD Review \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Time: \_\_\_\_\_

APN/CRNA Review \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Time: \_\_\_\_\_

**This information is confidential and will not be released without your written permission.**