# LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICES

## PATIENT BILL OF RIGHTS

All Patients at the Las Vegas Paiute Tribe Health and Human Services Department Clinic are entitled to respect and dignity. They have a right to health care that is considerate, respectful and culturally sensitive. Your Patient's Rights are as follows:

**Privacy and Confidentiality:**
The right to privacy and confidentiality concerning medical records, treatments, examinations, case discussions, case presentation and other information. The patient has the right to refuse the presence of and limited treatment by heath care students.

**Personal Safety:**
The right to expect reasonable safety insofar.as the health clinic's practices and environment are concerned.

**Identity:**
The right to know the name and qualifications of the persons(s) who will be responsible for his or her treatment.

**Information Disclosure:**
Patients have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

**Consultation:**
The patient has the right at their own expense to seek and consult with private health care professionals.

**Consent:**
The right to be informed of the medical procedures and treatments. The physician must provide all information necessary for the patient to make a decision as to whether the procedure or treatment is acceptable, including an explanation of the risk involved, whether or not any incapacity for normal living will result and if there are any alternative forms of treatment. In Life Threatening Emergency situations, the physician would not be responsible for providing extensive information if it would further jeopardize the wellbeing of the patient.

**Refusal of Treatment:**
The right to refuse treatment to the extent provided by the law. If health care services are refused, the patient must be informed of the risks incurred by doing so. The patient is responsible for any deterioration of their health condition when treatment is refused and health care provider's instructions are not followed. If a minor refuses treatment, the designated/legal representative must be told of the risks incurred if treatment for the minor is refused.

**Transfer Continuity of Care:**
When Health Care Services are not available at our clinics, the patient and their designated/legal representative will be informed about the availability of specialized care at another center/clinic/hospital. The patient has a right to expect reasonable referrals for continuity of care for his or her condition or illness.

## PATIENTS RESPONSIBILITIES

Your care depends partially on you. Therefore, in addition to your "Patient Rights," you have certain responsibilities as well, you may be dismissed from care or refused care if you do not adhere to them. These responsibilities are presented to you in the spirit of mutual trust and respect.

1. Provide to the best of your knowledge, accurate and complete information about present symptoms, past illnesses and hospitalizations, medication usage and other matters relating to your health.
2. Follow the treatment plan as recommended by your provider.
3. Report unrepentant changes in your medical condition to your provider.
4. Understand your course of treatment, including pain relief options, as outlined by your provider, nurse and other health care providers.
5. Keep your scheduled appointments with the health care providers and always notify them within **24 hours** if you are unable to keep your appointment.
6. Please arrive **15 minutes** early prior to your appointment for proper filled paperwork. If you will be **10 minutes** late, we will re-schedule your appointment.
7. Your conduct at each visit to the Clinic will remain appropriate at all times, including during your Clinic appointment.
8. Take the responsibility for all consequences if you refuse medical treatment or do not follow provider's orders or instructions.
9. Assure that your financial obligations to the Clinic and your health care providers are fulfilled as promptly as possible.
10. Follow all Clinic rules and regulations affecting your care.
11. Be considerate of the rights, privacy and property of other patient, visitors and Clinic staff.
12. Provide the Clinics with a copy of your written directives if available.
13. You will not consume any drugs, alcoholic beverages or toxic substances before or during your medical appointments in our clinic.
14. If your conduct and behavior is disruptive, the Las Vegas Tribal Police will be contacted to escort you off the Clinic property.
15. If your conduct continues to be disruptive to others during your Clinic visit, the Clinic can temporary or permanently discontinue providing services.

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES**
Public Health Service
Health Resources and Services Administration
***Las Vegas Paiute Tribe Health & Human Services***

# WHY WE ASK QUESTIONS

Privacy Act Notification Statement of the Las Vegas Paiute Tribe Health & Human Services

## BENEFITS

Reasons why Las Vegas Paiute Tribe Health and Human Services (LVPTHHS) and Purchase Referred Care (PRC) need to collect information from and about you:

- find out how you feel or what you think is wrong;
- To find out if a member of your family has a condition that could affect your health;
- To locate your health record among all the others;
- To reach you and your family (for follow-up care or to mail medical test results or future appointments to you) to maintain your health;
- To determine your health condition and the kind of care that is right for your health;
- If you give complete and correct information to the best of your ability then LVPTHHS staff will be better able to decide what proper care is needed.

## USES

LVPTHHS personnel will not reveal to anyone what is in your health record without your written permission, except to:

- State, local or other authorized groups to provide health service to you or to reimburse contractors for the services provided to you.
- Federally approved or healthcare oversight organizations that evaluate the health care you receive
- Persons performing health related research projects, which have been approved by the LVPTHHS
- Tribal, State or Federal government agencies which by law requires the information for the purposes of law enforcement, birth and death reporting and communicable disease control
- Local schools for the purpose of providing health care to the children they teach
- Organizations (Medicare/Medicaid, insurance companies) for them to reimburse LVPTHHS and contract health service providers for services provided to you.

## ELIGIBILITY

Information is required if we are to determine:

- Your eligibility to receive health care from the LVPTHHS;
- Your eligibility based on proof of enrollment or decent of a federally recognized Native American tribe;
- Your eligibility based on proof of residency (rent/utility receipt).

## LAST RESORT

Other information is required if we are to determine:

- Your eligibility to have other agencies such as Medicare, Medicaid or private insurance companies pay LVPTHHS for part or all of your health care expenses;
- Your eligibility to receive health care from other organizations (such as the Veterans Administration).

**These requirements are contained in 42 CFR Section 36.12 and 42 CFR Section 36.23. These regulations say that LVPTHHS is to obtain information on possible use of other health resources which may be used to provide you with health care. This information is to be obtained before health care is provided to you directly by LVPTHHS or by contract health providers.**

## AUTHORITY

Records of health care provided to you are maintained by LVPTHHS under the following laws:

- Public Health Service Act, Section 321
- Indian Self-Determination and Education Assistance Act;
- Snyder Act
- Indian Health Care Improvement Act;
- Construction of Community Hospital Act
- Indian Health Service Transfer Act.

## DISCLOSURE

**LVPTHHS EMPLOYEES ARE REQUIRED TO KEEP A LIST OF PEOPLE TO WHOM THEY RELEASE INFORMATION FROM YOUR HEALTH RECORD. YOU HAVE A RIGHT TO SEE THAT LIST. THE LIST MUST SHOW WHAT WAS RELEASE, TO WHOM (NAME AND ADDRESS), FOR WHAT PURPOSE AND THE DATE OF RELEASE. YOU MAY SPEAK WITH A PERSON AT THE FRONT DESK TO FIND OUT HOW TO DO THIS.**

# NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights to your protected health information, which you can exercises by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- File a complaint.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 1, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a complaint:

**Las Vegas Paiute Tribe Health & Human Services**
(Acting Privacy Officer)
1257 Paiute Circle Las Vegas, NV 89106
(702)382-0784

# Las Vegas Paiute Tribe Health & Human Services

## Protected Health Information of Medical Records

| *Patient Name* | *Date of Birth* |
|---|---|
| *Phone Number* | *Email Address* |

☐ I give permission to Las Vegas Paiute Tribe HHS to leave a voicemail message for me at the Preferred Phone Number listed above.

☐ I give permission to Las Vegas Paiute Tribe HHS to **VERBALLY** discuss information about me with: (optional)

Name: _____ Relationship: _____ phone: _____

Name: _____ Relationship: _____ phone: _____

Name: _____ Relationship: _____ phone: _____

Check all boxes that apply:

- ☐ Scheduling / Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan Billing and payment information
- ☐ Other (describe): _____

**Disclaimer: certain sensitive health information (treatment/testing) are specifically protected and will not be disclosed in the clinic setting without specific authorization. This includes the following:**

- Mental/Behavioral Health Records
- Alcohol/Drug Dependency Treatment
- HIV Testing Results/ AIDS Treatment
- Sexually Transmitted Diseases (STD)
- Genetic Testing/ Test results

☐ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as cited in the Notice of Privacy Practices.

☐ I understand that authorizing the disclosure of this health information is voluntary. LVPT HHS and its entities will not condition treatment, payment, enrollment or the eligibility for the benefits for providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the health information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which obtained from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event, or condition: _____
**If I fail to specify a date this authorization will expire 12 months from the signature in this form.**

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I give authorization on behalf of the name patient.

_____ Date: _____
Signature of Patient/Authorized Representative

**(If authorized representative, please sign and attach copies of supporting legal documentation.)**

# Las Vegas Paiute Tribe Health & Human Services

## General Consent for Care & Treatment

**TO THE PATIENT: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.**

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ Date: _____
Signature of Patient or Personal Representative

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

# Las Vegas Paiute Tribe Health & Human Services

## Telemedicine Patient Consent

**Patient Name: _____ DOB: _____**

**PURPOSE:** The purpose of this consent form is to obtain your consent to participate on telemedicine sessions with your provider. By signing the consent form, you agree to participate in telemedicine sessions with Las Vegas Paiute Tribe HHS.

**NATURE OF TELEMEDICINE CONSULT** During the telemedicine visit:

A) Details of your medical history, examination(s), radiology and labs will be discussed with you through the use of interactive video, audio, and telecommunication technology.
B) A physical examination if you may take place.

**MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine visit. The telemedicine visit will not be recorded or stored.

**CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality, risks associated with telehealth services and all existing confidentiality protections under federal and state laws apply to information disclosed during all telehealth sessions.**

a) The system that will be used during our telehealth session is in compliance with HIPAA rules and regulations, however it is your responsibility to be in a private environment in order to ensure that your information is protected.
b) The provider has the right to refuse completing the telehealth session if he/she feels the surrounding environment is not appropriate or private enough in order to protect the privacy of the patients.

**TELEMEDICINE ACCESS:** The Patient Accepts That He/she needs Access to PC, laptop, Or Mobile Device and A Good Internet Connection in Order to Have an Efficient Telemedicine appointment. I understand that telemedicine session can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

**PATIENT RIGHTS:** The Patient Can Withdraw his/her Consent at Any Time without affecting your rights to future care and/or treatment.

By signing this form, I understand that all laws that are protecting my privacy of medical history or information are also applied to telemedicine practices. I understand that I can withdraw the consent at any time that will not affect any of my future treatment procedures. I accept that I authorize my healthcare professional to utilize telemedicine for my treatment and diagnosis. I agree to the terms and conditions of receiving telemedicine visits.

_____ _____

Signature of patient or authorized representative Date:

# DIRECT CARE

**This Form Contains Important Information Regarding Your Health Care.**

**WHO is Eligible?**

To be eligible for Direct Care Services you must be a member or descendent of a federally recognized Native American Tribe in the United States.

**WHAT Services Are Provided?**

Direct Care Services are primary health care services provided by the professional staff of the Las Vegas Paiute Tribe Health & Human Services (LVPTHHS). Primary medical and behavioral health care services are provided at no cost to you. Please note a referral form must be obtained for each doctor or provider visit even if it is on the same day.

**A FEE is charged by LVPTHHS for the following:**

- Clinic Pharmacy: There is a charge for pharmacy medications.
- Any laboratory or diagnostic testing performed **within** LVPTHHS clinic
- Optical materials, lab fees, and service
- Dental material, lab fees, and service

**Medical, drug, vision or dental insurance may offset some or all cost share.**

**LVPTHHS providers may refer you to a specialist for further medical care.**
**LVPTHHS is not responsible for payment for services received at any other medical facility including and not limited to:**

- Specialist office visits, Laboratory testing, radiology services and diagnostic testing

**I have read the above and understand that payment is due at the time services are rendered. _____ Initials**

If you have Health Insurance (Nevada Medicaid, Medicare, or Private Insurance), your insurance will be billed for services provided at LVPTHHS clinic.

If you do not have insurance or cannot pay for additional services, you may access the **Moapa Paiute Indian Clinic, Parker Indian Health Center or Phoenix Indian Medical Center** for management of your medical condition. These facilities are funded to provide full medical coverage for all Native Americans.

Your care depends partially on you. Therefore, in addition to your "Patient Rights" you have certain responsibilities as well. These responsibilities are presented to you in the "Patient Bill of Rights and Patient Responsibilities" page. You may be dismissed or refused care if you do not adhere to them. _____ Initials

Patient/Parent/Guardian: _____ Date: _____
Signature

Guarantor of Payment/Responsible Party: _____

Relationship to Patient: _____

# LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICES

## Assignment of Benefits Form

I, the undersigned, irrevocably assign to the provider/entity referenced above LVPTHHS, all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay the Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

**Patient Responsibility**

I acknowledge and agree that **I am responsible** for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

**Release of Information**

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date: _____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

# LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICES

## PATIENT REGISTRATION

FILL OUT THIS FORM COMPLETELY

Legal Name of Patient: _____
(First) (Last) (Middle) (suffix)

Preferred Name_____ Military Veteran: ☐ YES / ☐ NO

Marital Status: Single Married Divorced Widowed Social Security # _____ - _____- _____

Birth Date: _____/_____/_____ Place of Birth: City: _____ State: _____

Ethnicity: Hispanic or Non-Hispanic Gender Identity: _____ Race: _____

**Internet Access: If YES, E-Mail Address**: _____

Mailing Address: _____
(Street or Box Number) (City/State) (Zip)

Home Phone: _____ Cell Phone: _____-_____ -_____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____ -_____

Employer: _____ Primary Language: _____

Pharmacy: _____ Secondary Pharmacy: _____

**Are You an Enrolled Member or A Descendant of a Federally Recognized Tribe in The United States?** ☐ YES ☐ NO

Tribe of Membership: _____ Tribe Quantum: _____ Enrollment#: _____

**HEALTH INSURANCE INFORMATION -BRING YOUR CARD TO EVERY VISIT!**

***Medicare Patients: If you have a prescription card and secondary Insurance, please provide as it can affect payment.***

Name Of Health Insurance: _____ DATE Eligibility Began: _____

Policy# of Insurance _____ Policy Holder Name:_____

Policy Holder's DOB: _____ Policy holder's S.S.# _____-_____-_____ Patient Relationship to Holder: _____

**SECONDARY INS:**

Name Of Health Insurance: _____ DATE Eligibility Began: _____

Policy# of Insurance _____ Policy Holder Name:_____

Policy Holder's DOB: _____ Policy holder's S.S.# _____-_____-_____ Patient Relationship to Holder: _____

**I CERTIFY THE ABOVE INFORMATION TO BE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE THE LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICES TO VERIFY THE ACCURACY OF THIS APPLICATION.**

_____ **Date:** _____/_____/_____

**PATIENT SIGNATURE (Parent or Guardian if under 18)**

# *Patient History and System Review*

PATIENT: _____ DATE: _____

| **List Current Health Problems: (Place N/A If none)** | |
|---|---|
| **1.** _____ | **3.** _____ |
| **2.** _____ | **4.** _____ |

| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |

| **Allergies to medications** | |
|---|---|
| Name the Drug | Reaction You Had |
| | |
| | |

| **Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio | | |
|---|---|---|
| **Immunizations and dates:** | ☐ Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Chickenpox |
| | ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |

| **Surgeries** | | |
|---|---|---|
| Year | Reason | Hospital |
| | | |
| | | |

| **Other hospitalizations** | | |
|---|---|---|
| Year | Reason | Hospital |
| | | |
| | | |

## SYSTEMS REVIEW

**Have you had any of the following problems?**

- ☐ fever, chills, weight loss, sweats or don't feel well
- ☐ eye or vision problems (glaucoma, change in vision, etc.)
- ☐ problem with nose or throat (allergies, swallowing, or smell)
- ☐ heart problem (murmur, irregular beats, chest pain)
- ☐ lung problem (including asthma, emphysema, cough)
- ☐ bowel or stomach problems
- ☐ muscle or joint aches, injuries, swelling
- ☐ skin problems, rashes, concerning moles, breast problems
- ☐ headaches, weakness, numbness, coordination problems
- ☐ mood swings, depression, crying forgetfulness, hallucinations
- ☐ heat or cold intolerance, change in color of skin, diabetes
- ☐ anemia, easy bruising, blood disorders
- ☐ difficulty with urination, blood in urine, kidney stones, infections

## FAMILY HISTORY

| | Relation | | Relation |
|---|---|---|---|
| Breast Cancer | _____ | Colon Cancer | _____ |
| Prostate Cancer | _____ | Ovarian Cancer | _____ |
| Lung Cancer | _____ | Skin Cancer | _____ |
| Diabetes | _____ | Hypertension | _____ |
| Heart Disease | _____ | Lung problems | _____ |
| Other Health Problems | _____ | Alcoholism | _____ |

## SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | |
|---|---|---|---|
| **Alcohol** | Do you drink alcohol? ☐ Yes ☐ No | | |
| | How many drinks per week? | | |
| **Tobacco** | Do you use tobacco? ☐ Cigarettes – pks. /day ☐ # of years | ☐ Yes | ☐ No |
| **Drugs** | Do you currently use recreational or street drugs? | ☐ Yes | ☐ No |
| | Have you ever given yourself street drugs with a needle? | ☐ Yes | ☐ No |
| **Sex** | Are you sexually active? | ☐ Yes | ☐ No |
| | Any discomfort with intercourse? | ☐ Yes | ☐ No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | ☐ Yes | ☐ No |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | ☐ Yes | ☐ No |

## WOMEN ONLY

| | | |
|---|---|---|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | ☐ Yes | ☐ No |
| Number of pregnancies _____ Number of live births _____ | | |
| Are you pregnant or breastfeeding? | ☐ Yes | ☐ No |
| Have you had a D&C, hysterectomy, or Cesarean? | ☐ Yes | ☐ No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | ☐ Yes | ☐ No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | ☐ Yes | ☐ No |
| Date of last pap and rectal exam? | | |

## MEN ONLY

| | | |
|---|---|---|
| Do you feel burning discharge from penis? | ☐ Yes | ☐ No |
| Any difficulty with erection or ejaculation? | ☐ Yes | ☐ No |
| Any testicle pain or swelling? | ☐ Yes | ☐ No |
| Date of last prostate and rectal exam? | ☐ Yes | ☐ No |