

Place Client Label Here

Registration Sheet Please make sure that you fill in this form correctly and completely.

LAST NAME		FIRST NAME		MI		DATE OF BIRTH
MAILING ADDRESS		APT #	CITY	COUNTY	STATE	ZIP CODE
Can we contact you at the address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If NO, please provide an alternative address. C/O (Name)				ALTERNATIVE ADDRESS		
HOME PHONE ()		WORK PHONE ()		CELL PHONE ()		
Can we contact you at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we contact you on your cell? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E-MAIL ADDRESS				Can we e-mail you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
* We will not sell or distribute your e-mail address to anyone else				* If yes, please complete back of form		

Contact Information & Instructions

The information below will be used by Planned Parenthood (PP) when we need to contact you with an abnormal test result, or to remind you about (or reschedule) your appointment, or to send a monthly bill if you have an outstanding balance. Please be aware that **if you do not answer our calls or mail regarding an abnormal test, we will attempt to reach you through your emergency contact below.**

I understand that PP will never give medical information to anyone but me without my consent, so when calling me, PP can:

<input type="checkbox"/> Identify themselves as Planned Parenthood		<input type="checkbox"/> Identify themselves only as my "doctor's office"	
<input type="checkbox"/> Use a code name of _____ to leave a message for me to return the call; I understand that when I receive a message under this name that I must call Planned Parenthood.			
Who should we contact in case of an emergency?			
Name: _____		Phone: _____	
Relationship: _____			
TODAY'S DATE	YOUR AGE	YOUR SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
YOUR WEEKLY INCOME		YOUR FAMILY SIZE (including yourself)	
YOUR RACE <input type="checkbox"/> Caucasian (W) <input type="checkbox"/> Black (African-American) <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Alaskan Native/American Indian		YOUR ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
HIGHEST GRADE COMPLETED	ARE YOU A STUDENT NOW? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part time <input type="checkbox"/> Full time	NUMBER OF LIVING CHILDREN (Born to you)
DO YOU CURRENTLY USE CONDOMS? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		DO YOU CURRENTLY USE A BIRTH CONTROL METHOD? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHAT METHOD?

<u>OFFICE USE ONLY:</u>			
Reviewed by _____	Date _____	Reviewed by _____	Date _____
Reviewed by _____	Date _____	Reviewed by _____	Date _____

INITIAL HISTORY

**PLACE PATIENT LABEL
HERE**

Date: ___/___/___

A. REVIEW OF SYSTEMS:	
YES	NO
GENERAL	
	1. My health is generally good
	2. Unexplained weight loss or gain of more than 10lbs in the past year
	3. Night sweats/hot flashes
	4. Cancer. If yes, where/when?
	5. Tobacco use. Number of years: If yes, <input type="checkbox"/> smoking. How many/day? <input type="checkbox"/> chewing tobacco?
	6. Alcohol use. If yes, how many drinks/week?
	7. Are you being treated for any illness/condition now? If yes what?
	8. Do you currently take medicine prescription, over the counter or herbal? If yes, name: Do you take any folic acid supplements?
	9. Birth defects or genetic problems
	10. Eye problems (except glasses or contacts)
	11. Hearing problems
	12. Frequent nosebleeds
	13. Frequent sore throat
CARDIO-RESPIRATORY	
	14. Mitral Valve Prolapse
	15. Heart murmur
	16. Varicose veins
	17. Blood clots (head/leg/lungs)
	18. Stroke or stroke-like problems
	19. High blood pressure
	20. High cholesterol
	21. Chronic cough or other breathing problems/asthma
	22. Tuberculosis or exposure to tuberculosis
GASTROINTESTINAL	
	23. Stomach or bowel problems
	24. Liver problems (hepatitis or tumor, etc.)
	25. Gallbladder problems
GENITOURINARY	
	26. Bladder, urine leaks or kidney problems
	27. Uterine fibroids
	28. Ovarian cysts
	29. Breast lump or nipple discharge or surgery
	30. Vaginal discharge that itches/burns or has a bad odor
	31. Endometriosis
	32. Pain with sex / Other sex problems
	33. Previous abnormal pap. If yes, when?
	34. Did your mother take DES when she was pregnant with you to prevent a miscarriage?
	35. History of sexually transmitted infection. Check type: <input type="checkbox"/> chlamydia <input type="checkbox"/> gonorrhea <input type="checkbox"/> genital warts <input type="checkbox"/> herpes <input type="checkbox"/> syphilis <input type="checkbox"/> PID
MUSCULOSKELETAL	
	36. <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> Other: _____
SKIN	
	37. <input type="checkbox"/> Acne or other skin problems. If yes, what? _____ <input type="checkbox"/> Tattoo <input type="checkbox"/> piercing. If yes, Where? _____
NEUROLOGICAL	
	38. Migraine headaches /Aura (diagnosed by Dr./NP/PA)
	39. Seizures/epilepsy
	40. Numbness in arms/legs (recurring)
PSYCHOLOGICAL	
	41. Depression requiring treatment. Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychological problems?

A. (cont'd) REVIEW OF SYSTEMS			
YES	NO		
ENDOCRINE			
	42. Thyroid problems		
	43. Diabetes		
HEMATOLOGICAL/LYMPHATIC			
	44. Anemia (Low Iron)		
	45. Sickle cell disease / trait		
	46. Blood clotting disorder		
ALLERGY			
	47. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, to what? Type of reaction:		
IMMUNIZATION (Check the ones you have received)			
48. <input type="checkbox"/> Diphtheria	53. <input type="checkbox"/> Meningococcal		
49. <input type="checkbox"/> Hepatitis A	54. <input type="checkbox"/> Pneumococcal		
50. Hepatitis B: <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3	55. <input type="checkbox"/> Tetanus		
51. Human Papillomavirus (HPV): <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3	56. <input type="checkbox"/> Varicella (chicken pox)		
52. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)	57. Other:		
B. HOSPITALIZATION AND SURGERIES			
Year	Reason		
C. ACCIDENTS AND INJURIES			
Year	Reason		
D. FAMILY HISTORY			
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have your biological family (parents, brothers, sisters, grandparents) had any of the following?			
YES	NO	Diagnosis	Relative
		Osteoporosis	
		Diabetes	
		Heart disease / Heart attack / stroke before age 50	
		High blood cholesterol	
		Genetic problems	
		Cancer If yes, was the cancer: <input type="checkbox"/> Ovarian <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Other Gynecological	
		Blood clots	
		Other:	
ADDITIONAL COMMENTS / EXPLANATIONS (by number)			

PLEASE COMPLETE OTHER SIDE

**AUTHORIZATION FORM FOR USE OF E-MAIL COMMUNICATIONS
SCOPE OF PERMITTED E-MAIL COMMUNICATIONS**

I HEREBY AUTHORIZE PP OF NORTHEAST OHIO TO USE THE ABOVE E-MAIL ADDRESS TO COMMUNICATE WITH ME FOR THE FOLLOWING LIMITED PURPOSES:

- Send me appointment reminders
- Direct me to its website for forms or information prior to an appointment
- Ask me to phone the health center for additional information

I agree that use of e-mail communications will be limited to the purposes checked above and I will not use e-mail to communicate with PP of Northeast Ohio for any other purposes. **Under no circumstances will I use e-mail communications for urgent or emergency issues.** I further understand that e-mail messages are checked only on a limited basis and only during normal business hours.

I understand that the e-mail communications from PP of Northeast Ohio may contain some or all of the following information:

- o My Name, My Date of Birth, PP of Northeast Ohio Clinic name, location and phone number
- o Provider/Clinician name, Date and Time of Appointment

When I e-mail PP of Northeast Ohio, I will:

- o Put the reason for the message in the subject line of the e-mail.
- o Put my name and date of birth in the message.
- o Write my message short and to the point.

When I receive an e-mail message from PP of Northeast Ohio, I will use the reply feature on my computer to let acknowledge that I have received the message.

RISKS OF E-MAIL COMMUNICATIONS

E-mail communications are not reliable, secure or private. For example:

- E-mail messages can be intercepted by or subject to unauthorized access (i.e., hacking).
- E-mail messages may be misdirected, lost, or otherwise subject to transmission errors.
- E-mail messages may be from someone other than the named sender and are easier to forge than handwritten, signed papers.
- Anyone with access (whether authorized or obtained through improper means) to an e-mail account will have access to all messages in that e-mail account.
- Anyone with that receives or has access (whether authorized or obtained through improper means) to an e-mail message will be able to read, forward, copy, delete or otherwise manipulate the e-mail messages.
- E-mail messages cannot really be deleted.
- E-mail services have a right to save and check e-mail sent through their system.
- E-mail can spread viruses.

Without limiting the foregoing, I acknowledge and accept that e-mail communications sent pursuant to this Authorization will be sent from PP of Northeast Ohio and anyone that receives or has access to that e-mail will know that the message is from PP of Northeast Ohio and will be able to view the content of that e-mail.

This Authorization is made for the following purpose:

At my request, OR

Specify: _____

CONDITIONS OF AUTHORIZATION

1. I have read and agree to agree the Scope of Permitted E-mail Communications set forth above.
2. I have read and accept the Risks of E-mail Communications set forth above.
3. This Authorization will expire on (insert date or event): When revoked.
4. I may revoke this Authorization at any time by notifying PP of Northeast Ohio in writing, and it will be effective on the date notified except to the extent that PP of Northeast Ohio has already acted upon such Authorization.
5. Communications made pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
6. By authorizing use of e-mail communications, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form.
7. I have been offered a copy of this signed Authorization form.
8. I agree to release PP of Northeast Ohio from and hold PP of Northeast Ohio harmless for any liability that may arise as a result of or in connection with the use of e-mail technology in the context of my relationship with PP of Northeast Ohio, including but not limited to breaches of confidentiality or privacy arising the use of e-mail technology.

SIGNATURE OF PATIENT

DATE

OR _____
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE