Chart # _____
Careful Contact? Yes____ No____

CLIENT INFORMATION SHEET

Print Name_____ Birthdate_____ Age_____
Last First Middle Maiden

Address_____ Home # _____ Best time
Cell # _____ to call _____

_____ SS#____ - ____ - ____
City State Zip Code County

I work: ☐ Full time ☐ Part time ☐ I do NOT work Place of Work and/or School_____

Work Phone_____ Best time to call_____ ☐ E-mail address_____

Emergency Contact:_____ Phone #_____

I live with: ☐ Spouse/Partner ☐ Parents ☐ Others ☐ Alone How many people live in your home? _____

We must be able to contact you to give you test results. Please check **all** the ways we may contact you:

☐ Call home ☐ Call work ☐ Call Home as "Heidi" ☐ Call Cell Phone ☐ Mail at home ☐ Plain envelope ☐ E-mail ☐ Other

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Because we receive federal funds, we must collect this information about you:

You may check more than one: ☐ White ☐ African American/Black ☐ American Indian/Alaskan Native

☐ Asian ☐ Pacific Islander/Native Hawaiian ☐ Unknown

Please check one: Origin: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Are you covered by public health insurance such as Medicaid, Medicare, CHIP, TRICARE/CHAMPUS, CHAMPVA or Kids Connection? ☐ Yes ☐ No ☐ Unknown

Are you covered by private health insurance? ☐ Yes ☐ No ☐ Unknown

Does your insurance cover Family Planning? ☐ Yes ☐ No ☐ Unknown

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☐ I wish to apply for reduced fees and will give staff complete and honest information about my income.

☐ I do NOT wish to apply for reduced fees. ☐ Bill my insurance. ☐ Bill Medicaid # _____

LIST ALL SOURCES OF FINANCIAL SUPPORT (show all amounts before any deductions)

Source Of Income:
- Your employment (pay stubs) Monthly Amount:_____
- Spouse/partner or Parent employment _____
- Dependent Children (AFDC/ADC) _____
- Child Support and/or Alimony _____
- SSI, Unemployment compensation _____
- Social Security, pension, railroad retirement, insurance & annuity payments _____
- Dividends, interest, rental income, trust funds _____
- Other sources (tips, allowances, etc.) _____

How many people including yourself, does this income support? _____

Cost for services is based on a sliding fee scale. You are responsible for any fees that there may be.

Patient Signature_____ Date_____

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

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FOR OFFICE USE ONLY: Staff Initials/Date _____

VERIFIED TOTAL MONTHLY INCOME_____ INCOME CODE: A(1) B(2) C(3) D(4) E(5)

3rd party: Ins Medicaid EWM

MALE MEDICAL HISTORY

NAME_____ **AGE** _____ **DOB** _____

Marital Status S M D W Separated Living with someone **Allergies**_____

Hospitalizations/Surgery_____ **Current Meds**(including Over the Counter)_____

Major Illnesses/Injuries_____ _____

Reason for today's visit:_____

Family MD:_____ Date of Last Visit:_____ Abnormal Findings: Y N

Do you use: Tobacco products? Y N, Amount _____ Alcohol? Y N, Amount_____ Drugs Y N if yes type/amount_____

Have You had: German Measles(Rubella)? Yes No Are you vaccinated for Rubella? Y N Unknown

Did you recieve Normal Childhood Vaccinations? Y N

Family History: Has any member of your family(parents,siblings,grandparents) had any of the following? Please Mark all that apply and state relationship:

❑Check here if you do not know your biological family history

❑Diabetes_____ ❑Stroke_____ ❑Heart Disease_____ ❑Blood Clots_____

❑High Blood Pressure_____ ❑High Cholesterol_____ ❑Sickle Cell Anemia_____

❑ Cancer(if yes, type and relationship)_____

❑Birth Defects/Genetic Diseases(if yes, type and relationship)_____ ❑Other_____

Past Medical History: Do you have, or have you ever had(Check all that apply):

GENERAL
- ❑Frequent or Severe Headaches
- ❑Unexplained Weight loss
- ❑Dizziness/Fainting
- ❑Seizures/Epilepsy/Convulsions
- ❑Skin Disorders
- ❑Leg pain/tenderness,swelling
- ❑Joint Pain
- ❑Recent Chills/Fever
- ❑Weight Problems

HEENT
- ❑Vision Problems (blurring/double vision, spots)
- ❑Hearing Problems
- ❑Difficulty Swallowing
- ❑Runny Nose

LUNGS
- ❑Chronic Cough
- ❑Hay Fever
- ❑Asthma
- ❑TB

BLOOD
- ❑Transfusions/Blood Products
- ❑Anemia
- ❑High Cholesterol
- ❑Blood Clots
- ❑Unusual Bruising
- ❑Blood Disorders
- ❑Injectable Drug Use

PSYCHOSOCIAL
- ❑Depression/Anxiety
- ❑History of Abuse
- ❑Suicidal Thoughts

ENDOCRINE
- ❑Diabetes
- ❑Thyroid Disorder
- ❑Increased Thirst

HEART
- ❑Chest pain
- ❑Difficulty Breathing
- ❑Rheumatic Fever
- ❑Mitral Valve Prolapse
- ❑Heart Murmur
- ❑High Blood Pressure
- ❑Stroke

ABDOMEN
- ❑Gallbladder Disease
- ❑Gastric Ulcers
- ❑Heartburn
- ❑Pain

LIVER
- ❑Hepatitis
- ❑Jaundice
- ❑Mononucleosis

CANCER ❑TYPE_____

BREASTS
- ❑Lump
- ❑Nipple Discharge

BOWELS
- ❑Constipation/Diarrhea
- ❑Blood in Stool
- ❑Rectal Pain/Bleeding

UROLOGICAL/GENITAL HISTORY

- ❑Kidney/Bladder Problems or Infections
- ❑Blood in Urine
- ❑Nighttime Urination
- ❑Pain, burning, difficulty or frequent urination
- ❑Injury to testicles or groin
- ❑Hernia/Hydrocele/Varicocele
- ❑Discharge from Penis
- ❑Sores/Bumps/Rash in genital area
- ❑Pain/bleeding with ejaculation or intercourse

Have you urinated in the last hour Yes No

Other Concerns/Pertinent History:_____

_____

_____

_____

SEXUAL HISTORY

Are you currently Sexually Active Yes No
Lifetime Sexual Partners:_____
Age of First Intercourse:_____
Are your current and past partners: Male Female Both
How many current sexual partners do you have?_____
Has your current or past sexual partner(s) had an STI or HIV?
Yes No Unknown, If yes type_____
Has your current or past sexual partner(s)had multiple partners or was bisexual(having sex with men and women)? Yes No
Do your current or past sexual partner(s) inject drugs? Yes No
Have you had more than one sexual partner in the last 6 months? Yes No
What types of Sex do you have: Vaginal Oral Anal
❑Sexually Transmitted Infection(Gonorrhea,Chlamydia,Warts,Herpes,Hepatitis)
Type:_____
❑Do you have HIV? Yes No Unknown
Do you wish to be tested for HIV? Yes No
Have you ever been forced into an activity you did not want to do? Yes No

FAMILY PLANS

Have you fathered any children? Yes No, if yes how many___
Do you plan future children? Yes No Undecided
Are you and your partner(s) currently using birth control?
❑Yes ❑No ❑Unsure, if yes, which type(s)?_____
Do you want more information about birth control? Yes No

NUTRITION

How many servings of the following do eat per day: Fruits_____Vegetables_____Nuts/Beans_____
Eggs/Meats_____Milk/Dairy_____Caffeine_____

EDUCATION:

Physical Exam	❑	Condom Fact Sheet	❑	Nutrition	❑
Emergency Information	❑	Smoking Cessation	❑	Available Clinic Services	❑
STI's/HIV	❑	Alcohol/Drug Abuse	❑ NA ❑	Importance of exams and testing	❑
Female/Male Anatomy	❑ NA ❑	Abuse	❑ NA ❑		
Exercise	❑ NA ❑	Contraceptive Options	❑		
Adolescent Ed.	❑ NA ❑	(to include NFP, effective use of methods, benefits and efficacy of methods)			

(to include Abstinence, Family involvement, Contraception, safer sex, & sexual coercion)

ASSURANCE OF CONFIDENTIALITY

This medical record is confidential and will not be released to anyone without your written consent, except as may be required by law.

To the best of my knowledge, the above history is accurate and complete. Educational information has been given to me as indicated above. I have been given the opportunity to ask questions. If I am 18 years old or younger, I have been strongly encouraged to discuss my family planning needs with my parents. If I use tobacco, I have been given information and understand the health risk of using tobacco. I have been told that if tests are taken for sexually transmitted infections (STI's), reporting of positive results to public health agencies is required by law. I understand that the Nebraska Health and Human Services may access my medical record to determine the quality of services provided by this agency.

CONSENT TO TREATMENT: I hereby consent to examination, consultation, and treatment at this clinic.

Patient Signature:_____ Staff Signature:_____ Date:_____

SEXUAL HEALTH ASSESSMENT

- Please circle your appropriate age group: Under 24 25 – 40 41 or older
- Have you had any of the following:
  - ⇒ New or multiple partners in the last 90 days? Yes No
  - ⇒ Contact with a partner with a sexually transmitted disease? Yes No
  - ⇒ Signs and/or symptoms of a sexually transmitted disease? Yes No

  If yes, check all that apply:
  - _____ Vaginal discharge that you feel is not normal for you
  - _____ Spotting between periods
  - _____ Pain with sexual intercourse
  - _____ Painful periods
  - _____ Urinary burning
- Have you recently had unprotected sex? Yes No
- Do you use condoms? Yes No If yes, how often? _____
- Do you have sex with:
  - ☐ Men
  - ☐ Women
  - ☐ Both men and women
- Do you have:
  - ☐ Vaginal sex
  - ☐ Oral Sex
  - ☐ Anal sex
- Have you ever had an STD? Yes No
- Do you use:
  - ☐ Alcohol
  - ☐ Drugs, other than those prescribed for you
  - ☐ IV Drugs
- Is your partner currently incarcerated or has your partner been released from a correctional facility (jail, prison, etc.) within the last year? Yes No
- Did you have a blood transfusion or were you given other blood products **BEFORE** 1985?
  Yes No

(DO NOT FILE IN PATIENT MEDICAL RECORD)