Colorado West WomanCare
of the Grand Valley
Community HOSPITAL

2373 G Road, Suite 240
Grand Junction, CO 81505
Phone (970) 243-7908
Fax (970) 245-0656

Provider you are scheduled to see:

□ Elizabeth McCarrel, M.D.
□ Tiffini Young, CNM □ Analiesa Leonhardt, CNM □ Sarah Boblett, CNM □ Sue Hanson, CNM

Patient Information Update

Date:______________________

Full Name: __________________________ **Preferred Name:** ___________________ **Maiden Name:** ____________________

Date of Birth: _______________ **Social Security Number**: ________________ **Preferred Pharmacy:** ____________________

Marital Status: Single Married Divorced Widow Primary Language: _____________________

Significant other's name: ___________________________ Date of Birth: _______________________

Race: □American Indian/Alaska Native □Asian □Black/African American
□Nat Hawaiian/Pacific Islander □White □ Other □ Decline

Ethnicity: □Hispanic or Latino □ Not Hispanic or Latino □Unknown □ Declined Religion: _________________________

Mailing Address: ______________________________ **City:** _________________________ **State:** _________ **Zip:** ___________

Primary Number: ___________________________ **Work:** _________________________ **Cell:** ___________________________

Employer: ________________________________ **Occupation:** __________________________ **Education:** _________________

Email Address: ____________________________ **Emergency Contact:** _______________________ **Phone:** _________________

□ **Self-Pay** □ **Insurance Company/Prescriber & D.O.B, if other than self:**___________________________________
May we leave messages regarding appointments or request for your call back on an answering machine? (Information includes doctor's name and appointment day/time) □Yes □No If yes, telephone number: ________________________

Patient Medical History

What brings you to our office today? **Height:** ___________________

□ Routine GYN check-up □ Pregnancy □ Other (please explain): ____

Who is your primary care physician? _________________________ **Referring physician?** ______________________________

Are you allergic to any medications? □Yes □No

Type	Reaction

Social History

Are you sexually active? □Yes □No Any new partners within the last year? □Yes How many? _____ □ No
Is your relationship monogamous? □Yes □No

Sexual preference: □Heterosexual □Homosexual □Bisexual □Decline

Have you ever been sexually abused or assaulted? □Yes □No If yes, what age? _____________

Do you ever feel unsafe at home? □Yes □No Have you ever felt afraid of your partner? □Yes □No

Please check all that apply:

□ Tobacco How many per day? ___________ For how many years? _______ Quit? When: _______________

□ Chew How much per day? ___________ For how many years? _______ Quit? When: _______________

□ Alcohol How much? __________________ □ Caffeine/Coffee How much? ________________

□ Recreational Drugs What type? ________________ How often? ___________ Quit? When: _____________

Any sexual partners with IV drug use? □Yes □No

Have you ever been treated for a drug or alcohol disorder? □Yes □No If yes, when? _________________

Gynecological History

Age of first cycle: ________ Date of your last menstrual cycle: ____________ Was it normal? □Yes □No

Number of days between cycles: ________ Menstrual flow is: □Light □Medium □Heavy

Do you have any of the following with your menses? (Please check all that apply)

□ Pain with or prior to your menstrual cycle □ Clots with cycle

□ Bleeding between cycles □ Abnormal vaginal bleeding

□ Bleeding during or after intercourse □ Pain with intercourse

Method of birth control:

□Condoms □Pills □Patch □Vaginal ring □Tubal □Essure □IUD: Which one? ____________

□Hysterectomy □Partner with vasectomy □None □Other _____________________

Have you had any of the following?

□Fibrocystic breasts □Endometriosis □Ovarian cysts □Uterine fibroids

Date of last Pap Smear: ___________________ Result: □Normal □Abnormal

If abnormal, did you have any of the following procedures?

□Colposcopy □Cryosurgery □LEEP □None

Date of last Mammogram: _________________ Result: □Normal □Abnormal

Do you know how to do a self-breast exam? □Yes □No

Do you examine your breasts monthly? □Yes □No

Date of last Bone Density: _________________ Result: □Normal □Abnormal

Date of last Colonoscopy: _________________ Result: □Normal □Abnormal

Have you experienced Menopause? □Yes □No (If yes, please check all that apply)

□Abnormal bleeding □Hot flashes □Lumps in your breasts □Discharge from your nipples

□Loss of urine when you cough or sneeze □Vaginal dryness □Pain with intercourse

If menopausal, have you ever used hormone replacement therapy? □Yes □No

Pregnancy History

Total number of pregnancies: __________ Number of stillbirths: _________________

Number of living children: _____________ Number of miscarriages: ______________

Number of premature births: ___________ Number of abortions: _________________

Please list pregnancies - starting with most recent

Date:	Sex:	Weight:	Complications: preterm labor, diabetes, high blood pressure, c-section

Have you been treated for infertility? □Yes □No

If yes, please describe when and the treatment received: ____

____

Medications

(Prescriptions, over-the-counter, vitamins, herbal/alternative meds)

Medication Name:	Dosage:	How Often:

Operations

(Starting with the most recent)

Year:	Type	Complications:

Immunizations & Sexually Transmitted Diseases

Date of last Tetanus: ________________

Date of last Measles, Mumps, and Rubella (MMR): ________________

Date of Human Papillomavirus Vaccine (HPV): ______________

Have you ever had any of the following?

□ German Measles When: _____________

□ Chicken Pox When: _____________

□ Vaginal Herpes (HSV) When: _____________

□ Chlamydia When: _____________

□ Gonorrhea When: _____________

□ Pelvic Infection When: _____________

□ Human Papillomavirus (HPV) When: _____________

□ Yeast Infection When: _____________

□ Bacterial Infection When: _____________

Treated? □ Yes □ No

Treated? □ Yes □ No

Treated? □ Yes □ No

Please Check All That Apply

Cardiovascular

- ☐ History of High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Blood Transfusion
  Date: ____________
- ☐ Anemia
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ History of Mitral Valve Prolapse
- ☐ Heart Disease or Murmurs
- ☐ History of Blood Clots in Legs

Urinary

- ☐ History of Kidney Infection
- ☐ History of Kidney Disease
- ☐ Blood or Sugar in Urine
- ☐ History of Bladder Infection
- ☐ History of Kidney Stones

Metabolic

- ☐ Thyroid Problems
- ☐ Diabetic
- ☐ Weight varied over 10 LBS in last year

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of Breath

Nose, Mouth, & Throat

- ☐ Frequent Nose Bleeds
- ☐ Dentures
- ☐ Sore, Sensitive, Bleeding Gums

Neuromuscular

- ☐ History of Convulsions
- ☐ Paralysis or Deformity
- ☐ Hearing Impaired
- ☐ Glasses
- ☐ Swollen, red, or Stiff Joints

Gastrointestinal

- ☐ Special Diet
- ☐ Bloody/Tarry Stools
- ☐ Chronic Constipation/Diarrhea
- ☐ Gallbladder Disease, Jaundice, Colitis, Hepatitis

☐ None of the above

Family History

(Please indicate if **you** or **any** member of your family has ever had any of the following)

The following family members should be considered: Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather

	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
□ Yes □ No Diabetes	_____	_______________	_______________
□ Yes □ No Heart Disease	_____	_______________	_______________
□ Yes □ No Hypertension	_____	_______________	_______________
□ Yes □ No Uterine (endometrial) cancer before age 50	_____	_______________	_______________
□ Yes □ No Colorectal Cancer before age 50	_____	_______________	_______________
□ Yes □ No Two or more Lynch syndrome cancers* in the same person or on the same side of the family	_____	_______________	_______________

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
□Yes □No Breast cancer at age 50 or younger	_____	_______________	_______________
□Yes □No Ovarian cancer	_____	_______________	_______________
□Yes □No Two unrelated breast cancers in the same person or on the same side of the family	_____	_______________	_______________
□Yes □No Male breast cancer	_____	_______________	_______________
□Yes □No Triple negative breast cancer (ER-, PR-, HER2- pathology)	_____	_______________	_______________
□Yes □No Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family	_____	_______________	_______________
□Yes □No Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person	_____	_______________	_______________

□Yes □No Have you or any member of your family ever been tested for hereditary risk or cancer?

If yes, please explain: ____
____

Patient Signature: ______________________________ **Date:** ____________________

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Community Medical Group

Treatment Consent

CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray exams, medical or surgical treatments or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patients physician or surgeon. Further authorization is given to Community Hospital to use discretion in the preservation of tissue removed for diagnostic or confidential medical research purposes. Patients at this hospital may be seen by a licensed or unlicensed psychologist, counselor, or medical social worker, who may assist with counseling or discharge planning services.

NURSING CARE: This hospital provides only general duty nursing care unless, upon orders of the patients physician, the patient is provided more intensive nursing care. If the patients condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that patient is not provided with such additional care.

LEGAL RELATIONSHIP BETWEEN HOSPTIAL AND PHYSICIAN: All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and other hospital based physicians, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care of the supervision of his/her attending physician and it is the responsibility of the physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under the general and special instruction of the physician.

PERSONAL VALUABLES: It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, purses, eyeglasses, dentures or other article of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient. It is further understood and agreed that any personal electric appliances brought in must be reported to the Nursing personnel.

FIANANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys fees and collection expenses.

ASSIGNEMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Community Hospital and hospital-based physicians of any insurance benefits otherwise payable to or on behalf of the undersigned for this hospitalization or for these outpatient services, including emergency services rendered not to exceed the hospital s regular charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that she/he is financially responsible for charges not covered by this assignment. If an assignment of insurance is made, and if the insurance company does not pay in 45 days, the undersigned agrees to make payment in full to Community Hospital for this account (exception; Medicare, Medicaid, and Colorado Indigent Care Program).

RELEASE OF INFORMATION: Upon inquiry, the hospital may make available certain basic information about the patient. Disclosure of Federal Social Security Number in reference to Medical Devices is mandated by the FDA per the safe Medical Devices Act of 1990 and also for other state and federally mandated requests.

The hospital will obtain the patients consent and his/her written authorization to release information, other than

basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital may disclose portions of the patients record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospitals charges, including but not limited to insurance companies, health care service plans, worker s compensation carriers, Radiologist, pathologists, and hospital-based physicians. Disclosure is valid until full payment is received. The patient authorizes the release of medical, alcohol and drug information for this stay.

The undersigned agrees that Community Hospital may convey medical information for discharge planning purposes and to release medical information to primary care and referring physician(s). The undersigned will further authorize that information from the patients' health care records may be used for research purposes to the extent that such information be handled in non-identifying manner as to preserve confidentiality.

FINANCIAL RESPONSIBILITY AGREEMENT BY THE PATIENT OR THE PATIENTS LEGAL RESPRESENTAIVE: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment, Assignment of Insurance Benefits and Health Care Service Plan Obligation Provisions above.

X-RAY AND RADIOLOGICAL PROCEDURES: All x-rays and radiological procedures you receive while in this department will be read by a certified radiologist and billed separately from the Community Hospital charges. You will receive a bill from Diagnostic Radiologists, P.C. for the x-ray/procedure readings. If you have insurance, it will be billed and you will be responsible for any balance owing after your insurance pays. Your signature below acknowledges your understanding and acceptance of the billing and your responsibility for payment.

ACKNOWLEGEMENT OF RECEIPT:
My signature only acknowledges my receipt of this message from Community Hospital.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or the patients legal representative, or is duly authorized by the patient as the patients general agent to execute the above and accepts its terms.

Patient Name: **Guarantor Name (Responsible Party):**

Patient or Parent/Guardian Signature:

Date/Time:

Witness:

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Acknowledgement of Privacy Practices / Non-Discrimination Policy

I understand that, as part of my healthcare, this practice maintains health information about me describing my health history, symptoms, test results, and diagnoses. This information serves as: (1) a basis for planning my care and treatment, (2) a means of communication among the health professionals providing my care, and (3) a source of information for preparing my bill.

The Practices' Notice of Privacy Practices provides information about how the practice may use and disclose protected health information about me.

Discrimination is against the law. Community Hospital, and all of its affiliate facilities, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

By signing this form, I acknowledge that I have received or been offered a copy of Community Hospital's Non-Discrimination Policy.

Patient Name: ____ D.O.B: ________________

Signature: ____ Date: _________________

Patient Release of Information

I, ________________________________, authorize that medical information can be given by telephone or in person to the following individual(s):

Name	Relationship

This authorization expires one year from the date of this document or when voided by me. ___________
Initial here