Welcome Center
8007 Excelsior Drive, MC 9740
Madison, WI 53717

Office: 608.821.4819
Fax: 608.833-3203
uwhealth.org/welcomecenter

Selecting a PCP for Your New Quartz Health Insurance

Optional: Automatic Assignment of a UW Health Primary Care Physician (PCP)

When selecting a Quartz Health Insurance Plan, the UW Health Welcome Center will assist with:

- Selecting a primary care physician (PCP), via automatic assignment if desired,
  - More information on UW Health physicians can be found at: www.uwhealth.org/findadoctor/
- Transfer prior medical records, and
- Update your prior medical history into your new UW Health electronic medical record.

Would you like the UW Health Welcome Center to assist in PCP selection and transition to UW Health?

☐ Yes, auto assign a PCP for me/my family within a UW Health Clinic near my home address.

What type of Quartz Health Insurance coverage have you selected?

☐ Single
☐ Family

Please complete all applicable fields:

Relation	First and Last Name	Date of Birth	Preferred Daytime Phone Number
Resident/ Fellow			
Spouse			
Child			
Child			
Child			

To complete your UW Health health care transition, please complete the following forms:

- Health History form (for each family member, as applicable)
- Authorization for Disclosure of Protected Health Information
  - Requires original signature; eSignatures are not accepted
  - One form for each family member and prior medical facility, for past two years
- Authorization for Verbal Communication (Optional)

Return all completed forms by mail or fax:

- **Mail:** UW Health Welcome Center, 8007 Excelsior Drive WC 9740, Madison, WI 53717
- **Fax:** 608-833-3203 (regardless of the fax numbers listed on forms)

By signing this form, I confirm selection of coverage with Quartz Health Insurance by submission of the ETF Health Insurance application, available via Oracle, and give permission for *UW Health Welcome Center* to assist in the selection of a primary care physician.

Signed: _____ Date: _____

Tips for Use of Authorization for Release of Verbal Communication AND Exchange of Written Information

PURPOSE: To ensure authorization is on file for current and future sharing of information between those listed in Sections 2 and 3 only
Examples for use (but not limited to):

- School issues (ADD, IEP, asthma or other chronic conditions) communicated with and released to school staff
- Working with payers to certify/pre-approve services
- Coordination of community/social services (excluded from continuity of care purposes which doesn't require an authorization)
- Coordination of medical services where special authorization is required: Mental Health, Substance Use Disorder, HIV test results where both verbal AND written authorization is needed

Examples **NOT** for use:

- NOT INTENDED FOR HIM (Health Information Management) TO IMMEDIATELY RELEASE COPIES – ONLY THE PERSON LISTED IN SECTIONS 2 AND 3 MAY SHARE
- Provider to provider exchange of PHI (does not require authorization)
- For the sole purpose of releasing copies of PHI
    - Use form UWH1280490-DT Authorization for Disclosure of Protected Health Information
- For the sole purpose of authorizing verbal communication
    - Use form UWH302443-DT Authorization for Verbal Communication and/or to Leave Voice Mail Messages

Form Completion Tips:
Section 1 – Use label with MRN and DOB, if not already pre-populated when printing from Cadence
Section 2 – Check either UW Health or a particular clinic/unit or specific person authorized to exchange information

- Least Restrictive: Organization
- Moderately Restrictive: Smaller section within an organization
- Most Restrictive: List an individual person (limits the exchange for that person only)

Section 3 – Enter name of organization/person authorized to receive/exchange information with that listed in Section 2

- Least Restrictive: Organization
- Moderately Restrictive: Smaller section within an organization
- Most Restrictive: Individual person (including first and last name)
- Full address should be included to allow for exchange of PHI
- Phone number is only required when authorized to communicate via telephone and/or leave voice mail messages
- **NOTE**: Only one person/organization may be listed per authorization. If multiple people/organizations are desired, an authorization is required for each one, except for mother/father from same household

Sections 4 and 5 – Include what type(s) of information can be shared, if different from ANY AND ALL – These boxes are pre-checked as both situations must apply in order to use this authorization

- Section 4 – **(Must Be Completed)** Written: Can be defined by condition/diagnosis (asthma, ADD, lung cancer), date range (past 5 years), or other (specific forms/tests/procedures, etc.)
- Section 5 – Verbal: Two-way communication

Section 6 – Additional options for voice mail – Check box if patient authorizes voice mail messages to be left at the number listed in Section 3

- If patient authorizes leaving detailed voice mail on the patient's own voice mail, the Authorization for Verbal Communication and/or to Leave Voice Mail Messages (UWH302443-DT) should be used instead of this form
- Authorization includes any information to be left on voice mail, unless patient specifies on the authorization such limitations (example: no lab results, no OB appointment information, etc.)

Section 7 – Purpose of disclosure – Care Coordination is prepopulated as a default. If other reason, please enter
Section 8 – Authorization expiration – Standard expiration date will be one year from date of signature unless a new date is entered – if a longer period of time is requested by the patient, a five-year range is a good timeframe to use

- **NEW**: The option of Indefinite has been removed in order to reduce the risk of unknown authorization over a long period of time (patient forgets about an indefinite authorization)

Authorization paragraph:
This authorization includes disclosure of information regarding **substance use disorder, psychiatric consults and mental illness, developmental disabilities, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results,** unless the patient chooses to limit the information authorized.

- To do that, they must list the limitations in the space provided

Signature of Patient/Representative: Signed by person legally authorized to sign
Signature of Guardian – Guardianship is a legally authorized designation – see FYI flag and scanned document for appropriate legal papers

- Stepparent cannot sign unless legal papers are on file

Date – Enter the date in which the patient/representative/guardian signed the authorization
Patient is/Legal Authority – Complete if Guardian/Representative is completed

UW Health

Index to Auth – Exchange Information

AUTHORIZATION FOR RELEASE OF VERBAL COMMUNICATION AND EXCHANGE OF WRITTEN INFORMATION

Health Information Management
8501 Excelsior Drive
Madison, WI 53717
Fax: (608) 662-4444

1. Patient Information

Name – Last, First, MI (Maiden or former name)			
Street Address	City	State	Zip Code
Medical Record Number (only if known)	Birthdate	Phone Number	

2. Exchange of Information between: ☐ UW Health (or):

Name – (e.g. Health Facility, Physician…)		
Address		
City	State	Zip Code
Phone Number	Fax	

3. And: (Only one person/organization/phone# per authorization)

Name – (e.g. Insurance Company, Lawyer, Physician, Patient)		
Address		
City	State	Zip Code
Phone Number	Fax	

Information to be disclosed: **BOTH verbal and written information** - if only one is exclusively being requested, use *Authorization for Disclosure of Protected Health Information (UWH1280490-DT) or Authorization for Verbal Communication and/or to Leave Voice Mail Messages (UWH302443-DT).*

4. ☒ **Written Medical Record Documentation to be Disclosed**: Includes ANY and ALL records unless otherwise specified below:
Records pertaining to (dates or conditions): _____

Other (describe): _____

AND

5. ☒ **Exchange of Verbal Communication between those listed in Sections 2 & 3**

6. ☐ Additional option to leave **VOICE MAIL** to those listed in Section 3
Voice mail includes any information unless specified: _____

7. Purpose or need for disclosure: Care Coordination unless otherwise specified: _____

8. This authorization will expire one year from signature unless otherwise indicated below:
☐ Other specific expiration date (specify): _____/_____/_____

****PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the next page of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding substance use disorder, psychiatric consults and mental illness, developmental disabilities, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following:_____

_____

Signature of Patient/Representative: _____ Date: ____/____/____

If signed by person other than the patient, print name and state relationship and authority to do so. (See next page for information about signatures)

Print Name: _____ Relationship: _____

Patient is:	☐ Minor	☐ Incompetent/Incapacitated	☐ Spouse/Domestic Partner of Deceased
Legal Authority:	☐ Legal Guardian	☐ Parent of Minor	☐ Next of Kin
	☐ Health Care Agent		☐ Other: _____
	☐ Personal Representative		

ADDITIONAL INFORMATION REGARDING AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

UW Health care providers honor a patient's right to confidentiality of protected health information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Release of Information: The information released may be obtained from the medical record of UW Health. It may be obtained from multiple paper-based or electronic-based forms (as applicable). It may include data elements from outside sources that are embedded in tables and documents. Copies released from Health Information Management include medical records only.

Sending Authorizations to UW Health: Authorizations for UW Health sites can be mailed to **UW Health - Health Information Management, 8501 Excelsior Drive, Madison, WI 53717**. See a detailed listing of clinics that release their own records on uwhealth.org. This information is located in the Patient and Visitor section, How to Obtain Your Medical Records.

Federal HIPAA Privacy Rules: These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information. You can find a copy of the Notice of Privacy Practices on the website at uwhealth.org. This information is located on the bottom right corner of the website. Click on Notice of Privacy Practices (HIPAA).

Federal Substance Use Disorder Treatment Program Privacy (42 CFR Part 2): The federal confidentiality rules (42 CFR Part 2) that apply to substance use disorder treatment and/or referral records maintained by a Part 2 program prohibit any further disclosure of such records without the specific written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. However, any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by federal privacy standards.

Wisconsin Right to Privacy: Wisconsin law protects the confidentiality of patient healthcare records and indicates when records may be disclosed without your authorization.

General Designation for Disclosure of Substance Use Disorder Treatment Information: I understand I have made a general designation to disclose substance use disorder treatment and/or referral information to individuals or entities with which I have a treatment relationship. I may request a list of individuals or entities to which my substance use disorder information has been disclosed by contacting UW Health – Health Information Management (Release of Information), 8501 Excelsior Drive, Madison, WI 53717, (608) 263-6030, Option 3.

No Obligation to Sign: You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UW Health care providers may not refuse to provide you treatment or other healthcare services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the previous page of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. For UW Health records, your revocation must be made in writing, signed by you or your legal representative, and delivered to: UW Health - Health Information Management (Release of Information), 8501 Excelsior Drive, Madison, WI 53717.

Re-release: If the person(s) and/or organization(s) authorized by this form to receive your protected health information are not healthcare providers or other people who are subject to federal health privacy laws, the protected health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your protected health information without your prior permission.

Right to Inspect: You have the right to inspect or copy the protected health information for whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Patient Accounting department (for billing records) or Health Information Management department (for medical records) at 8501 Excelsior Drive, Madison, WI 53717, or (608) 263-6030, Option 3.

Fees: There is no charge for records requested by or released to other healthcare organizations. A fee will be charged for other requested purposes. See uwhealth.org for more details on fees assessed or call Release of Information during normal business hours at (608) 263-6030, Option 5.

Multiple Formats for Release of Medical Records (Paper vs DVD): You may request records to be provided to you in different formats; however, only one format will be released per authorization. You will be asked to submit a separate request for each format if multiple formats are desired (and may be charged for each request).

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign this form to authorize the disclosure of your protected health information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact: UW Health - Health Information Management, 8501 Excelsior Drive, Madison, WI 53717, (608) 263-6030, Option 3.

INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- NOTE that if an authorization is needed for disclosure of a patient's medical information for purposes of fundraising or marketing, a separate form is required. Such forms are available at the Marketing & Public Affairs web page of the UW Health intranet.
- Item #2a Medical Records to obtain: Description must be specific enough so that the patient can understand what information he or she is permitting to be disclosed. Thus, if "Other" section is used, description must be reasonably detailed (select one section per authorization). Select one box below for the records needed.
- Item #2b Substance Use Disorder (SUD) Records: Select all boxes that apply.
- Item #2c Format for record delivery: Select one box (paper, DVD or Other) for the format of records to be released. If this is left blank, records will be provided in paper format.
- Item #2d Medical Images to be disclosed from: Indicate the location where Medical images are from.
- Item #2e Specific Medical Images to be disclosed: Indicate if all medical images are needed or specific images relating to particular studies or dates.
- Item #3 Release Information FROM: Indicate the name of the organization to which records are to be released from (Select <u>one</u> per authorization) or write in the facility name and full address, phone and fax number.
- Item #4 Release Information TO: Indicate the specific person(s) or class(es) of persons outside the entity who will be permitted to receive the information with full mailing address, phone and fax number.
- Item #5 Purpose or need for disclosure - may be released electronically: Indicate any and all purposes for disclosure.
- Item #6 Expiration date: Enter specific expiration date if applicable.
- <u>Signatures</u>: In general, a patient age 18 or older is the only person with legal authority to sign this form. For patients younger than 18, generally the patient's parent or legal guardian must sign on behalf of the patient. There are many exceptions, however, to these general rules. For example:
    - If the patient has a guardian, the form may be signed by the patient's guardian or temporary guardian. If there is no guardian, and if two physicians have determined that the patient is incompetent, the form may be signed by the healthcare agent named in the patient's power of attorney.
    - If the patient is authorizing the use of HIV test results, he or she is permitted to sign this form regardless of age. If the patient is under the age of 14, a parent or guardian may sign on his or her behalf. If the patient is age 14 or older, a parent or guardian may not sign on his or her behalf.
    - If the patient is authorizing the use or disclosure of medical records involving treatment for mental illness, developmental disabilities, alcoholism or drug dependence, the patient is permitted to sign this form if he or she is age 12 or older. If the patient is between the ages of 12 and 18, a parent or guardian may sign on his or her behalf. If the patient is under the age of 12, a parent or guardian must sign.
    - For deceased patients, this form may be signed by the patient's surviving spouse or personal representative. If there is no surviving spouse or personal representative, immediate family members may sign. For this purpose, immediate family members are limited to adult children, parents, grandparents, and adult brothers and adult sisters of the deceased patient and their spouses.
    - All individuals signing for disclosure of medical information on behalf of a patient must state their relationship to the patient and may be required to provide proof of legal authority to permit the use or disclosure of the medical information.
    - For information about signatures in other situations or answers to questions about these issues, please contact your supervisor, the Director of Health Information, and/or the Privacy Officer.
- The patient must be given a copy of the signed authorization form if the Authorization was initiated from within a UW Health care provider as opposed to the patient or a third party.

UW Health

Index to Auth-PHI

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Information Management
8501 Excelsior Drive
Madison, WI 53717
Fax: (608) 203-4580

1. Patient Information

Name – Last, First, MI (Maiden or former name)			
Street Address	City	State	Zip Code
Medical Record Number (only if known)	Birthdate	Phone Number	

2a. Medical Records to obtain (Select one) – for Medical Images/Films, see below under 2d and 2e	**2b. Substance Use Disorder (SUD) Records – will only be released if selected below (Please select all that apply)**
☐ Summary of Chart (includes discharge summaries, consultations, emergency room records, outpatient notes, pathology reports, clinic summaries, X-ray (reports only), EKG and Lab reports for the most recent two years)	☐ SUD assessments ☐ Treatment notes and treatment plans ☐ Lab screening results ☐ Discharge Summary including SUD information
☐ Records pertaining to (dates or conditions): _____	☐ All SUD information **from** date ____/____/____ **to** date ____/____/____
☐ Other (describe):_____	☐ Other: _____
☐ Entire medical record from date ____/____/____to date ____/____/____	

2c. Format for record delivery (Select one): ☐ Paper ☐ DVD (requires PDF viewer) ☐ Other format (specify): _____
Please note: If a format is not selected, records will be provided in paper format.

2d. MEDICAL IMAGES to be disclosed from (Select one): ☐ UW Health ☐ UW Health Rehab Hospital

2e. Specific MEDICAL IMAGES to be disclosed:
☐ All Radiology Images ☐ All Cardiology Studies ☐ All Surgery Photos
☐ All Eye/Ophthalmology Studies ☐ Images pertaining to: _____
(dates and/or studies)

3. Release Information FROM: (Select one)
☐ All UW Health or Specify below:
☐ UW Health Rehab Hospital or
☐ Other Healthcare Organization (Complete below)

Name – (e.g. Health Facility, Physician…)		
Address		
City	State	Zip Code
Phone Number	Fax	

4. Release Information TO: **Need full mailing address**

Name – (e.g. Insurance Company, Lawyer, Physician, Patient)		
UW Health Welcome Center		
Address		
8007 Excelsior Drive, WC 9740		
City	State	Zip Code
Madison	WI	53717
Phone Number	Fax	
(608) 821-4819	(608) 662-2488	

5. Purpose or need for disclosure - may be released electronically. (Select all applicable categories)
☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation ☐ Workers' compensation
☐ Application for insurance ☐ Vocational rehabilitation ☐ Patient use ☐ Research
☐ Disability determination ☐ Other: _____

6. EXPIRATION DATE: This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. (NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.) ☐ Other specific expiration date: ____/____/____

****PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the next page of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding substance use disorder, psychiatric consults and mental illness, developmental disabilities, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following: _____

Signature of Patient/Representative: _____ **Date**: ____/____/____

If signed by person other than the patient, print name and state relationship and authority to do so. (See next page for more information)

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Spouse/Domestic Partner of Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Next of Kin
☐ Health Care Agent ☐ Other: _____
☐ Personal Representative

UW Health Release Documentation

ADDITIONAL INFORMATION REGARDING AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Federal HIPAA Privacy Rules: These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information. You can find a copy of the Notice of Privacy Practices on the website at uwhealth.org. This information is located on the bottom right corner of the website. Click on Notice of Privacy Practices (HIPAA).

Federal Substance Use Disorder Treatment Program Privacy (42 CFR Part 2): The federal confidentiality rules (42 CFR Part 2) that apply to substance use disorder treatment and/or referral records maintained by a Part 2 program prohibit any further disclosure of such records without the specific written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. However, any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by federal privacy standards.

Wisconsin Right to Privacy: Wisconsin law protects the confidentiality of patient healthcare records and indicates when records may be disclosed without your authorization.

General Designation for Disclosure of Substance Use Disorder Treatment Information: I understand I have made a general designation to disclose substance use disorder treatment and/or referral information to individuals or entities with which I have a treatment relationship. I may request a list of individuals or entities to which my substance use disorder information has been disclosed by contacting UW Health – Health Information Management (Release of Information), 8501 Excelsior Drive, Madison, WI 53717, (608) 263-6030, Option 3.

No Obligation to Sign: You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UW Health care providers may not refuse to provide you treatment or other healthcare services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the previous page of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. For UW Health records, your revocation must be made in writing, signed by you or your legal representative, and delivered to: UW Health - Health Information Management (Release of Information), 8501 Excelsior Drive, Madison, WI 53717.

Re-release: If the person(s) and/or organization(s) authorized by this form to receive your protected health information are not healthcare providers or other people who are subject to federal health privacy laws, the protected health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your protected health information without your prior permission.

Right to Inspect: You have the right to inspect or copy the protected health information for whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Patient Accounting department (for billing records) or Health Information Management department (for medical records) at 8501 Excelsior Drive Madison, WI 53717 or (608) 263-6030, Option 3.

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UWHealth

* If you are unsure of any area(s), it is fine to leave them blank and you may discuss it with your physician.

Please return this form to:
Fax: 608-833-3203
Mail: UW Health Welcome Center, 8007 Excelsior Drive, WC 9740, Madison, WI 53717

Today's Date: _____ **Phone Number:** _____

Name: _____ **Date of Birth:** _____

UW Health Primary Care Physician (*if known*): _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Education (# of years): _____ **Occupation:** _____

Advanced Care Planning: Do you have a Health Care Power of Attorney? Yes ☐ No ☐

Do you have a Living Will? Yes ☐ No ☐

If yes, please bring a copy to your 1st appointment.

Present Medical Concerns:
None ☐

_____

_____

_____

Allergies: (Food and/or Medication) List specific allergen and specific reaction (e.g. Amoxicillin causes hives and itching):
None ☐

_____

_____

_____

Tobacco Use: Never Smoked ☐

Current *Every* Day Smoker: Yes, for _____ Years Packs per Day: _____

Current *Some* Day Smoker: Yes, for _____ Years Packs per Day/Week/Month: _____

Exposure to Secondhand Smoke: Yes, for _____ Years

Former Smoker: Yes, for _____ Years Date Quit: _____

Comment(s):

_____

_____

Name: _____ **Date of Birth:** _____

If answered yes to Tobacco Use or Exposure, please check all that apply:

Cigarettes: ☐ Chew: ☐ Cigars: ☐
Pipe: ☐ Snuff: ☐

Alcohol Use: No ☐
Yes ☐ Type: _____ Drinks per week: _____
Comment(s):

_____

_____

Illicit Drug Use: No ☐
Yes ☐ Type: _____ Times per week: _____
Comment(s):

_____

_____

Sexual Activity:
Partners: Male(s) ☐ Female(s) ☐ Not Currently: Yes ☐ No ☐

Birth Control or Other Contraception: _____
Comment(s):

_____

_____

Are you currently, or have you ever been, in a relationship where you were physically hurt, threatened, pressured to have sexual contact or made to feel afraid?

Currently: Yes ☐ No ☐ In the Past: Yes ☐ No ☐

Activities of Daily Living

Military Service:	No ☐ Yes ☐	Special Diet:	No ☐ Yes ☐
Blood Transfusion:	No ☐ Yes ☐	Back Care:	No ☐ Yes ☐
Caffeine:	No ☐ Yes ☐	Exercise:	No ☐ Yes ☐
Use per week: _____		Type: _____	
Occupational Exposure:	No ☐ Yes ☐	Times per week: _____	
Hobby Hazards:	No ☐ Yes ☐	Bike Helmet:	No ☐ Yes ☐
Sleep Concern:	No ☐ Yes ☐	Seatbelt:	No ☐ Yes ☐
Weight Concern:	No ☐ Yes ☐	Self-Exams (Breast, Testicular):	No ☐ Yes ☐

Name: _____ **Date of Birth:** _____

Health Maintenance Tests (as applicable):

Date of last Mammogram: _____ Where performed? _____ or N/A ☐

Date of last Colonoscopy: _____ Where performed? _____ or N/A ☐

Date of last Pap Smear: _____ Where performed? _____ or N/A ☐

Date of last Bone Density: _____ Where performed? _____ or N/A ☐

Medications: Prescription and over the counter taken on a CONSISTENT basis (e.g. Ranitidine 150 mg twice a day):
None ☐

	Medication	Dose	Directions/Time per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Thank you for completing your health history information.