HOPE CLINIC
a community health center

MEDICAL HISTORY REVIEW
OB/GYN

OFFICE USE ONLY:	WEIGHT: _____	B/P: _____	PULSE: _____	HEIGHT: _____	EDD: _____

Last Name: _____ **First Name**: _____ **DOB**: _____

PATIENT INFORMATION:

Please review the information below and write in any corrections or missing information

Please check Yes or No for the following questions:

Do you feel little interest or pleasure in doing things?	❒ Yes	❒ No
Are you feeling down, depressed, or hopeless?	❒ Yes	❒ No

CURRENT MEDICATIONS:

Please list any medications you are currently taking. Please include the strength of the pill (eg Ibuprofen 250mg). Also list any over the counter (OTC) or non-prescription medications you have recently taken.

Drug Name & Strength:	Frequency/Instructions:	Prescribing Physician:

MEDICAL HISTORY

Have YOU been diagnosed with any of the following diseases or had any of the following problems? Please circle Yes or No. Use the notes column to specify when you were diagnosed with that disease or when you last had symptoms.

Disease/Problem:	**Yes**	**No**	**Notes:**
Diabetes	Yes	No	
Thyroid problems	Yes	No	
Hypertension (High blood pressure)	Yes	No	
Heart disease	Yes	No	
Blood clots in the veins	Yes	No	
Respiratory problems	Yes	No	
Kidney Disease	Yes	No	
Hepatitis	Yes	No	
Autoimmune Disease	Yes	No	
Tuberculosis	Yes	No	
Neurologic problems	Yes	No	
Psychiatric problems	Yes	No	
Trauma/Domestic Violence	Yes	No	
Anemia/Blood Disease	Yes	No	
Other	Yes	No	

ALLERGIES (please include allergies to medication or latex)

Medication Name:	Reaction/Severity:

GYN HISTORY:

Date of last pap smear: _____ **Have you had abnormal pap smears?** ❒ Yes ❒ No

MENSTRUAL HISTORY

Age at first period: _____ years **Menses monthly:** ❒ YES ❒ NO **Frequency:** _____ days

First day of last menstrual period: _____
Month Day Year

BIRTH CONTROL
What birth control method(s) do you currently use (ex. condoms, birth control pills, IUD, etc)? _____

PREGNANCY HISTORY (ALL PREGNANCIES):

☐ Check here if you have **NEVER** been pregnant

TOTAL PREG	FULL TERM	PREMATURE	ABORTIONS	MISCARRIAGES	ECTOPICS	MULTIPLE BIRTHS	LIVING

PAST PREGNANCY DETAILS (LAST SIX)

Month/ Date/ Year	Duration of Pregnancy	Length of Labor	Child's Birth Weight	Child's Sex (M / F)	Delivery Type (Vaginal/ C-section)	Anesthesia used	Place of Delivery/ Abortion	Preterm Labor Yes/No	Comments/Complications

How many siblings do you have? Brothers: _____ Sisters: _____

If you are currently pregnant, please complete the "Genetics" section, if not please proceed to the "Surgical/Hospitalization History"

GENETICS:

Has any of your family members or the father of the baby's family members have a history of the following? Please circle Yes or No. If you answered Yes, please specify which family members were diagnosed with each disease

Type	Yes	No	Notes:
Patient's age > 35 years as of estimated date of delivery	Yes	No	
Recurrent pregnancy loss or a stillbirth	Yes	No	
Thalassemia (Italian, Greek, Mediterranean or Asian); MCV <80	Yes	No	
Neural Tube defect	Yes	No	
Congenital Heart defect	Yes	No	
Down Syndrome	Yes	No	
Tay-Sachs	Yes	No	
Canavan disease	Yes	No	
Sickle cell disease or trait	Yes	No	
Hemophilia or other blood disorders	Yes	No	
Muscular dystrophy	Yes	No	
Cystic Fibrosis	Yes	No	
Mental Retardation/Autism	Yes	No	
If yes, was person tested for fragile X	Yes	No	
Maternal metabolic disorder	Yes	No	
Other inherited genetic or chromosomal disorder	Yes	No	
Patient or baby's father had a child with birth defects not listed	Yes	No	
Medications/Illicit/Recreational drugs/alcohol since last menstrual period	Yes	No	
If yes, Agent(s) and strength/dosage	Yes	No	

INFECTION HISTORY (Fill out only if pregnant)

Please answer the following questions. If you answered Yes, please specify with details in the notes column.

Type	Yes	No	Notes
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis	Yes	No	
Patient or partner with genital herpes	Yes	No	
Live with someone with TB or exposed to TB	Yes	No	
Rash or viral illness since last menstrual period	Yes	No	

SURGICAL/HOSPITALIZATION HISTORY

Please list the dates you were hospitalized or had surgery and the reason for each.

Date	Hospitalization Reason / Surgery

FAMILY HISTORY

Has any of **your family members** been diagnosed with any of the following diseases? Please circle Yes or No. If you answered Yes, please specify which family members were diagnosed with each disease.

Disease/Problem:	**Yes**	**No**	**Family Member** (Ex. Brother, Mother, etc.)	**Side of the Family (Circle one)**	**Alive / Deceased (Circle one)**
High blood pressure/Stroke	Yes	No		Mother / Father	Alive / Deceased
Diabetes	Yes	No		Mother / Father	Alive / Deceased
Epilepsy/Seizures	Yes	No		Mother / Father	Alive / Deceased
Kidney problems	Yes	No		Mother / Father	Alive / Deceased
Muscle/Bone disease	Yes	No		Mother / Father	Alive / Deceased
Genetic disease/major birth defect	Yes	No		Mother / Father	Alive / Deceased
Tuberculosis	Yes	No		Mother / Father	Alive / Deceased
HIV + individual in household	Yes	No		Mother / Father	Alive / Deceased
Mental retardation	Yes	No		Mother / Father	Alive / Deceased
Breast Cancer	Yes	No		Mother / Father	Alive / Deceased
Endometrial Cancer	Yes	No		Mother / Father	Alive / Deceased
Ovarian Cancer	Yes	No		Mother / Father	Alive / Deceased
Colon Cancer	Yes	No		Mother / Father	Alive / Deceased
Other medical problems: (please list below)					
				Mother / Father	Alive / Deceased

SOCIAL HISTORY

Please place a check by the sentence that best describes your status on the following:

	I have never smoked	I used to smoke	I currently smoke every day (If yes, how frequently?)	I currently smoke on some days (If yes, how frequently?)
Smoking				
Drugs				
Alcohol				

After completing and reviewing the above information, please initial and date below:

Patient Initials: _____ Date: _____

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PATIENT REGISTRATION/ REGISTRACION DEL PACIENTE

Today's Date/*Fecha*: _____ Date of Birth/ *Fecha De Nacimiento*: _____

Last Name/ Apellido: _____ First Name/Nombre: _____

Middle Name/Segundo Nombre _____ **Gender/ *Sexo*:** ☐ Female/ *Femenino* ☐ Male/ *Masculino*

Social Security #/ *Num. De Seguro Social:* _____

Address/ *Direccion*: _____ **Apt:** _____

City/ *Ciudad:* _____ State/ *Estado*: _____ Zip Code/ *Codigo Postal*: _____

Home Phone #/ *Num. de Casa*: _____ Cell Phone #/ *Num. De Celular*: _____

Can we leave a detail message on answering machine or voice mail?/ *Podemos dejar un mensaje detallado en la contestadora o correo de voz?* Please initial/escriba sus iniciales: Yes/ *Si*_____ No/ *No*_____

*E-mail Address/ *Correo Electronico*: _____ @ _____

Patient Marital Status/ Estatus Legal del paciente: ☐Single/soltero(a) ☐ Married/Casado(a) ☐ Divorced/ Divorciado(a) ☐Separated/Separado(a) ☐ Life Partner/Union Libre ☐Widowed/Viudo(a)

Do to the Privacy Act Bill: If you would like us to disclose any medical information to your family members, you must state their full name and sign below/ ***Si desea que divulguemos información médica a miembros de su familia, por favor indique el nombre(s) de las personas que usted autoriza a su medico o el personal de la Clinica Hope para discutir o proporcionar información medica(familia, amigos, ect) Porfavor firme.***

Name/ *Nombre*: _____ Phone#/ *Num. Telefonico*: _____

Relation/ *Relacion*: _____ Signature/ *Firma del Paciente/Guardian:* _____

EMERGENCY CONTACT/ CONTACTO DE EMERGENCIA*(Other than your primary phone numbers listed above/Diferente a los anteriores mencionados.)*Name/ *Nombre*: _____

Phone #/ *Num. Telefonico*: _____ Relationship/ Relacion: _____

INFORMACION DE LA ASEGURANZA MEDICA ☐NONE/ Ninguno ☐ **Medicaid** ☐ **CHIP**

☐ **Gold Card**/ *Tarjeta Dorada …* ☐**Private Insurance** / *Seguro Privado*(**Blue Cross, Aetna**,etc.)

Insurance Name/**Nombre de la aseguranza**	Id #/ **de miembro**	Policy holder name/ **Nombre de la persona acargo de la aseguranza**

Please Note: Hope clinic is not a free clinic. Patient charges are based on income and family size.
Por favor Nota: La clínica Hope no es una clínica gratuita. Cargos de los pacientes se basa en los ingresos y el tamaño de la familia.

Authorization to pay benefits
By signing below you acknowledge that you are financially responsible if full of your charges if you are self-pay; for the balance of your charges after any discount has been applied; and for any deductibles, co-pays or any services that your insurance does not cover
Autorización para pagar los beneficios
Al firmar este documento usted reconoce que usted es responsable económicamente si está lleno de sus cargos si son auto-pago, para el equilibrio de sus cargos después de algún tipo de descuento se ha aplicado, y de cualquier deducible, co-pago o cualquier otro servicio que su seguro no cubre.

Signature/Firma:_____ **Date/Fecha** _____

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DEMOGRAPHIC DATA / DATOS DEMOGRAFICOS

Are you from Spain or South America or Latin America/Es usted de Espana, America del sur o Latino americano?
☐ Yes ☐ No

Race/Raza: ☐American Indian/Indio Americano ☐Hispanic/Latino/Hispano ☐ Other/Otra:_____

Ethnic Group/Grupo etnico: ☐ Hispanic ☐ Other: _____

What is your primary language/Cual su primer idioma? ☐Spanish/Espanol ☐English/Ingles ☐Other/Otra: _____

Family Size/Cuantos personas hay en el hogar? _____Total monthly Income/ingreso mensual? $ _____.____

Are you a Veteran/Es veterano de guerra?	☐Yes/Si	☐No
Are you a season worker/Es un trabajador temporal?	☐Yes/Si	☐No
Are you a migrant worker/Es un trabajador migrate?	☐Yes/Si	☐No
Are you a refugee?/ Es refugiado?	☐ Yes/Si	☐ No
Are you a U.S citizen/Es ciudadano Americano?	☐Yes/Si	☐No
Are you Homeless/Es una persona desamparada?	☐Yes/Si	☐No
Are you a patient Assistant program/Recibe algun tipo de ayuda?	☐Yes/Si	☐No

(WIC,ESTAMPILLAS DE COMIDA,SSI,TANF, MEDICAID)

Do You Need A Translator/Necesita traductor?	☐Yes/Si	☐No
Are you pregnant/Esta embarazada?	☐Yes/Si	☐No

County/Condado: ☐Harris ☐Fort Bend ☐Galveston ☐Brazoria ☐Other

Age range/Su edad va de: ☐0-10 ☐11-19 ☐20-39 ☐40-49 ☐50-64 ☐65+

Employment status of the patient:/Estatus de empleo del paciente

☐Full time/tiempo completo ☐Part time/medio tiempo ☐Unemployment/desempleado ☐Self employment/dueno porpio ☐Retired/retirado ☐Other/otro

Student status/ Estatus de estudiante del paciente

☐Full time/tiempo completo ☐ Part time/medio tiempo ☐ not aplicable/ no applica

How did you hear about us/ Como supo de la clinica Hope? ☐ Friend/amigo ☐Relatives/parientes ☐Other Provider/otro doctor ☐School/la escuela ☐HCHD/el condado ☐Other/Otro

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CONSENT TO EXHANGE HEALTH INFORMATION
CONSENTIMIENTO DE INTERCAMBIO DE INFORMACION DE SALUD

I hereby give permission for HOPE CLINIC to obtain or release my health history electronically or by any other means from or to any other healthcare organizations, school healthcare officials, counselors, and professionals as related to my care.

Yo doy mi autorización para que la CLINICA HOPE obtenga mi historial médico electrónicamente o por cualquier otro medio de cualquier organización de atención medica o profesional relacionado a mi cuidado.

Printed name of patient/Nombre del paciente: _____

DOB/ Fecha de Nacimiento: _____/_____/_____

Patient or Guardian Signature /Firma del paciente o Tutor Legal: _____

Signature Date/ Fecha de la Firma: _____/_____/_____

PREFERRED PHARMACY/FARMACIA DE SU PREFERENCIA

☐ CVS ☐ EVERGREEN

☐ HEB ☐ WALGREENS

☐ WALMART ☐ KROGER

☐ OTRA _____

Corner of/ Interseccion : (ej. Fondren y Bellaire)_____ y_____

Pharmacy Telephone/ Teléfono de la Farmacia: (_____) _____-_____

Pharmacy Zip Code/ Codigo Postal de la Farmacia: _____

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AUTHORIZATION FOR MEDICAL CARE AND TO RELEASE MEDICAL INFORMATION

☐**I authorize HOPE Clinic medical employees to administer medical services that may reasonably be deemed necessary in diagnosing and treating my illness/injury.**

☐**I authorize HOPE Clinic to release any information acquired in the course of my examination or treatment to my referring physician or for the purpose of filing a medical claim.**

** The Privacy law 1) permits PHI disclosures without a written patient authorization for specified public health purposes to public health authorities legally authorized to collect and receive the information for such purposes, and 2) permits disclosures that are required by state and local public health or other laws.

** The privacy law permits covered entities to disclose PHI without authorization to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This includes the reporting of disease or injury: reporting vital events (e.g. births or deaths): conducting public health surveillance, investigations, or interventions; reporting child abuse and neglect, and monitoring adverse outcomes related to food (including dietary supplements) drugs, biological products, and medical devices [45 CFR 164.512 (b)]. Covered entities may report adverse events related to FDA-regulated products or activities to public agencies and private entities that are subject to FDA jurisdiction [45 CFR 164.512(b) (1) (iit)]. To protect the health of the public, public health authorities might need to obtain information related the individuals affected by a disease. In certain cases, they might need to contact those affected to determine the cause of the disease to allow for actions to prevent further illness. Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority [45 CFR 164.512 (b) (1) (i)].

** Special consent forms available upon request (STD. etc...)

** You may inspect or copy the protected health information to be used or disclosed under this authorization.
** You may revoke this authorization in writing by submitting a written revocation to this office. However, your revocation will not apply to action taken by this office prior to the date we receive your written request to revoke authorization

** I ☐**Accept** ☐**Decline a copy of the Hope Clinic Notice of Privacy Practices**

_____ _____

Signature/Firma Date/Fecha

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BOARD CERTIFIED NURSE PRACTITIONER
CONSENT TO TREAT

West Houston Ob/Gyn has on staff a board certified nurse practitioner to assist Dr. Korhonen in the delivery of obstetrical and gynecological care of our patients.

A Board Certified Nurse Practitioner is not a physician. She is a graduate of a certified training program, that she undertook after her RN degree, and is certified and licensed by the Texas State Board.

Under the supervision of a physician, she can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

Certified Nurse Practitioners may provide such medical services that are within the scope of education, training and experience. These services may include but are not limited to:

- Obtaining histories and performing well women exams.
- Ordering and or performing diagnostic and therapeutic procedures.
- Formulating a working diagnosis.
- Developing and implementing a treatment plan.
- Monitoring the effectiveness of therapeutic interventions.
- Offering counseling and education.
- Supplying sample medications and writing prescriptions.
- Making referrals.

I have read the above narrative and I hereby consent to the services of a Certified Nurse Practitioner for my healthcare needs.
I also understand that at any time I can refuse to see her and request to see a physician.

Name_____ Signature_____ Date_____

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CHILD'S NAME / *Nombre Del Paciente* _____

PARENT/GUARDIAN INFORMATION
INFORMACION DEL PADRE/ TUTOR LEGAL

[ ] **Father/Papa** [ ] Mother/ *Mama* [ ] **Legal Guardian/** *Tutor Legal*	
Parents Full Name/*Nombre Completo del padre y madre)* 1. _____ 2. _____	Parents Date of Birth/*Fecha De Nacimiento de los padres* *1.* ____/____/____ *Tel:* _____ *2.* ____/____/____ *Tel:* _____
What is the parents marital status? ***Estatus Legal de los padres*** [ ] Single/ *Soltero/a* [ ] Married/*Casado/a* … [ ] Divorced/ *Divorciado/a* [ ] Separated/Separado/a [ ] Life Partner/ Union Libre [ ] Widowed/viudo	E-mail/ *Correo Electronico*
Home Address/*Direccion* County/*Condado*	City, State, Zip code/ *Cuidad y Codigo Postal*
Do You Need A Translator? ***Necesita un traductor?*** [ ] Yes/Si… [ ] No	**Language/** ***Lenguaje*****:**

1. **Are you, the legal guardian?**
   Es el tutor legal del menor?
   [ ] Yes/Si… [ ] No

2. **Is the other biological parent involved in the child's care?**
   El otro padre biologico esta involucrado en el cuidado del menor?
   [ ] Yes/Si… [ ] No

Authorization for Non-Legal Guardians
Please provide the name(s) of individuals whom you authorize to bring your child to the doctor in case you are not available to bring him/her. (Include Step-parents, Grandparents, Aunts, etc.) *Por favor, indique el nombre (s) de las personas que usted autoriza a llevar a su hijo al médico en caso de que usted no pueda. (ej: padrastros, abuelos, tías, etc)*

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

_____ _____

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