GALLIA COUNTY HEALTH DEPARTMENT
Primary Care / Reproductive Health & Wellness Clinic

Name_____
(Last) (First) (MI)

Address_____
(Street) (City) (State) (Zip)

Date of Birth_____ Age _____ SS# _____

Home Phone _____ Cell Phone _____
Consent to Call? __YES __ NO Text? __YES __ NO

Parent/Guardian Name (If applicable) _____County of residence _____

Would you like access to the Patient Portal? __YES__ NO
Email_____

Emergency contact Name _____Relationship to Patient _____

Emergency Contact Phone Number _____

Race: (Please circle) White; Black; Asian/Pacific Islander; Native American; Biracial; Other (Specify) _____

Ethnicity: Non-Hispanic___ Hispanic ___

Primary Language _____

Marital Status: (Please circle) Single Married Separated Divorced Widowed

Number of People in your household _____ Are you currently a student? __YES __NO

Highest grade of school completed _____ Occupation_____

Place of Work _____ Work Phone _____

How did you hear about us? _____Preferred Pharmacy? _____

***Please complete the table below to the best of your ability. MANDATORY!!!!!!!!**

	Household member/Relationship	Source of Income	Amount of Income (per week, month or year)
1.			
2.			
3.			

Do you have private insurance? __ Yes __ No
Do you have a medical card? __ Yes __ No

If you have insurance, we will need a copy of the insurance card.

Initial here if you consent to the Release of Billing Information and Assignment of Benefits related to obtaining payment for this visit, and understand you may receive additional statements for services not covered by your insurance(s): _____

If uninsured and being seen through the Reproductive Health & Wellness Program, a sliding fee scale will be used to determine your costs; however, services will not be denied due to an inability to pay.
If uninsured and being seen through the Primary Care Clinic, there will be an office visit fee of $35.00. There will be additional fees for labs, if needed.
Are there any financial concerns in the home? ___Yes ___No

***Primary Reason for visit today: _____**

ALLERGIES (List anything that you are allergic to: medications, food, bee stings, etc.)

_____

MEDICATIONS (Please list all the medications you are taking - Include prescribed and over-the-counter drugs)

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		

Additional meds: _____

For Women Only

Date of Last Pap Smear? _____
If menopausal, age at Menopause? _____
HPV Vaccine? ____ YES ____NO IF YES, HOW MANY? _____
Sexually Active? ____ YES ____ NO
Sexual Problems? ____ YES ____ NO
STIs/ STDs ____ YES ____ NO If YES _____
Current Birth Control Method? _____
Desired Birth Control Method? _____
Most recent Mammogram? _____
Abnormal PAP? ____ YES ____ NO
Do you have a monthly cycle? ____ YES ____ NO
Age of first period? _____
Date of last period? _____
Total Pregnancies? _____
Full Term? _____
Premature? _____
Ectopic? _____
Multiple Births? _____
Living? _____

For Men Only

Are you experiencing testicular problems? ____ YES ____ NO
Do you perform monthly testicular self-exams? ____ YES _____ NO
How many children do you have? _____
Do you want to have children (more children) someday? ____ YES ____ NO
What is your or your partner's current birth control method? _____
Have you had a PSA Level in the past? ____ YES ____ NO
Prostate Present? ____ YES ____ NO
STIs/ STDs ____ YES ____ NO If YES _____

For Pediatric (Under 18) Patients ONLY

Are you in Daycare? ____ YES ____ NO
Name of Daycare: _____
Are you a student? ____ YES ____ NO GRADE: _____
Name of School: _____
Who do you live with? (Please circle) Both Parents Mother Father Grandparent Guardian Other: _____
Parents' Marriage Status: _____
How many siblings do you have? _____

Are you involved in sports? If yes, list sport(s):

_____

Have you had a lead screening? ____ YES ____ NO
Does someone in the household smoke? ____ YES ____ NO
Do you see a dentist? ____ YES ____ NO
Do you brush your teeth 2 times/day? ____ YES ____ NO
Do you experience bullying? ____ YES ____ NO

			SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY									
RELATION	ALIVE?	AGE	ALCOHOLISM	ARTHRITIS	DEPRESSION	CANCER	DIABETES	GENETIC DISEASE	HEART DISEASE	HIGH BLOOD PRESSURE	OSTEOPOROSIS	STROKE
GRANDMOTHER (MATERNAL)	☐ Y ☐ N											
GRANDFATHER (MATERNAL)	☐ Y ☐ N											
GRANDMOTHER (PATERNAL)	☐ Y ☐ N											
GRANDFATHER (PATERNAL)	☐ Y ☐ N											
FATHER	☐ Y ☐ N											
MOTHER	☐ Y ☐ N											
BROTHER/SISTER	☐ Y ☐ N											
BROTHER/SISTER	☐ Y ☐ N											
OTHER:	☐ Y ☐ N											

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			

PAST MEDICAL HISTORY (Please check all that apply)

☐ ADD/ADHD	☐ Gout
☐ Acid Reflux (GERD)	☐ Heart Disease
☐ Anemia	☐ Heart Problems
☐ Anxiety Disorder: _____	☐ Hepatitis
☐ Arthritis	☐ High Cholesterol
☐ Asthma	☐ History of STI
☐ Autoimmune Disease: _____	☐ High Blood Pressure
☐ Blood diseases: _____	☐ Overactive Thyroid
☐ COPD	☐ Underactive Thyroid
☐ Cancer	☐ Infertility
☐ Congestive Heart Failure	☐ Kidney Disease
☐ Depression	☐ Kidney Stones
☐ Dermatologic (Skin) Disorders	☐ Mental Disorder/Illness
☐ Diabetes – Type 1	☐ Osteoporosis
☐ Diabetes – Type 2	☐ Polyps
☐ Diverticulitis	☐ Pulmonary Embolism
☐ Ear or Hearing Problems	☐ Seizures/Epilepsy
☐ Endometriosis	☐ Stroke
☐ GI Problems	☐ Trauma/Violence
☐ Blindness	☐ Vision or Eye Problems
☐ Other:	

ADDITIONAL HEALTH FACTS

Please add other information about your health that you would like your provider to know here:

SOCIAL HISTORY

Are you able to care for yourself? ____ YES ____ NO
Are you blind or do you have serious difficulty seeing? ____ YES ____ NO
Are you deaf or do you have serious difficulty hearing? ____ YES ____ NO
Do you have difficulty concentrating, remembering, or making decisions?
____ YES ____ NO
Do you have difficulty walking or climbing stairs? ____ YES ____ NO
Do you have difficulty dressing or bathing? ____ YES ____ NO
Do you have difficulty doing errands alone? ____ YES ____ NO
Are you able to walk? ____ YES ____ NO
Do you have transportation difficulties? ____ YES ____ NO
Do you or have you ever smoked tobacco? ____ YES ____ NO ____ QUIT

At what age did you start smoking? _____
How much tobacco do you smoke? _____
Do you vape or use e-cigarettes? ____Nicotine ____CBD ____OTHER
Do you use smokeless tobacco? ____ Chew ____ Snuff ____ Moist Tobacco Powder

What age did you start smoking? _____

How much do you smoke?

Have you used IV drugs? ____YES ____NO

What is your level of alcohol consumption? ____ OCCASIONAL ____ MODERATE ____ HEAVY
How many years have you consumed alcohol? _____
Do you currently use recreational or street drugs? ____ YES ____ NO Please List:
_____

Do you have and advance directive? ____YES ____NO

Have there been any changes to your family or social situation? ____ YES ____ NO
Do you have any pets? ____ YES ____ NO
Do you have smoke and carbon monoxide detectors in the house? ____ YES ____ NO
Are you passively exposed to smoke? ____ YES ____ NO
Are there any guns present in the home? ____ YES ____ NO
Stress Level? ____ LOW ____ MEDIUM ____ HIGH
Are you sexually active? ____ YES ____ NO
If no, have you been sexually active in the past 6 months? ____ YES ____ NO
Do you use condoms? ____ ALWAYS ____ SOMETIMES ____ NEVER
Do you have multiple sexual partners? ____ YES ____ NO
Identify as: (Please circle) Male Female
Identify as: Straight Homosexual Bisexual Transgendered Pansexual Unknown

Exercise Level? ____NONE ____OCCASIONAL ____MODERATE ____HIGH
Caffeine Intake: # of cups/cans per day? _____
Diet: (Please circle) Regular Vegetarian Vegan Diabetic Gluten Free
Other: _____

Do you have a good support system? ____ YES ____ NO

Do you experience emotional/relationship problems? ___ YES ___ NO

Is there anyone who often says hurtful/mean things? ___ YES ___ NO

Is there anyone who is physically abusive? ____ YES ____ NO

If in the past, are you safe now? _____

Have you ever been diagnosed with depression or other mental health

condition? ____ YES ____ NO

Do you ever have thoughts of hurting yourself or others?

____ YES ____ NO

Do you feel safe in your home? ____ YES ____ NO

Have you been Vaccinated for COVID?
Which one? _____ Boosters? _____
Have you been exposed to COVID in the last 10 days that you are aware of? ____YES ____NO
Have you had a Flu Vaccine this year? ____YES ____NO

Do you use seatbelts? ___Yes ___ NO

Do you use sunscreen? ___Yes ___NO

Do you wear a helmet? ____Yes ____ NO

Do you use bug spray? ____Yes ____ NO

X_____ _____

Signature of patient or legal guardian **DATE**

GALLIA COUNTY HEALTH DEPARTMENT
PRIMARY CARE / REPRODUCTIVE HEALTH & WELLNESS CLINIC

Consent for the Provision of Medical Services and to Obtain and/or Release Records

NAME OF PATIENT:_____ **DATE OF BIRTH:**_____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form. As a state/federally supported program, the Reproductive Health and Wellness Program is required to provide data to the Ohio Department of Health about the clients we serve and our clinic activities.

I have been given information about the test(s), treatment(s), procedure(s), to be provided including the benefits, risks, possible problem/complications and alternative choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.
No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services and services are received on a voluntary basis. I know that I can change my mind at any time. Receipt of family planning services is not a prerequisite of any other services offered.
Services will be provided in a confidential manner; however, I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.
I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.
I understand that confidentiality will be maintained as much as legally possible. A copy of the HIPPA guidelines will be provided to me at my request.
I hereby request that a person authorized by the Gallia County Health Department provide appropriate evaluation, testing, treatment (including birth control drug, if I request it).
I understand that the information released may include treatment for physical and mental illness, alcohol, or drug use, AIDS or HIV testing.

I, _____, understand the need for medical care and consent to the services provided
(PATIENT NAME)
by the Gallia County Reproductive Health & Wellness Clinic/Primary Care Clinic. These services include: social and educational services, laboratory procedures, medical treatment, examinations, diagnostic procedures and other services deemed necessary by the clinician. I have been told and understand that the services provided are for medical care only and do not include emergency services. I give permission to **OBTAIN and/or RELEASE** my medical records to a Provider or organization concerned with providing further care or services to me. I release the staff of the Reproductive Health & Wellness Program/Primary Care Clinic from any liability resulting from disclosure of information in those medical records.

Patient Signature: _____ Witness: _____

Date: _____ Date: _____

If patient is a **minor under 18**:
Parent/Guardian Signature: _____ Relationship: _____

For Under 18 Minors WITHOUT Parental Consent Only

I, _____, a minor, have been told by the staff of the Gallia County Reproductive Health & Wellness Clinic the following: 1) the legal implications of not having the consent of a parent/guardian for care and services provided in this clinic. 2) that it is advisable to have written permission from a parent/guardian for the care and treatment provided in this clinic.
I do not, at this time, wish to inform my parent/guardian of my medical condition/pregnancy or of my involvement with the Reproductive Health & Wellness Program. The clinic staff has requested that I obtain the above-mentioned permission and I refuse to do so. This decision has been my own and I take full responsibility for my actions.

Patient: _____Witness: _____ Date: _____

GALLIA COUNTY HEALTH DEPARTMENT
PRIMARY CARE / REPRODUCTIVE HEALTH & WELLNESS CLINIC

Assignment of Insurance Benefits/ Financial Responsibility

I authorize payment of my insurance benefits directly to the Gallia County Health Department. I understand that I am financially responsible for charges not covered by this authorization, and all bills not paid in a timely manner by my insurance carrier. I hereby consent to receiving auto-dialed and/or artificial or pre-recorded message calls, and/or text messages to my mobile device and to any telephone number provided by me with this encounter from the Gallia County Health Department. I understand this consent includes without limitation, any account management companies and independent contractors, including without limitation, any debt collectors.

All cash pay visits for Primary Care are due at the time of service. If your appointment involves getting lab drawn, 50% of the lab cost are due at the time of the visit. If you are unable to pay the amount in full you will have 12 months to pay the amount in full. If the amount is not paid in full no appointments or labs will be performed until the previous amount is paid.

Any Reproductive visits will be applied to our sliding fee scale, based on your income and household size). There is a financial hardship program for Reproductive needs if needed, ask to discuss with a staff member.

For any Out-of-Network insurance e.g. (Ohio Medicare or VA) we will offer the cash pay option of a base fee of $35 Office Visit. If labs are drawn LabCorp will bill your insurance for the cost of labs.

Patient Name: _____ **DOB: _____**

Patient Signature: _____ **Date: _____**

Witness: _____ **Date: _____**