PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____

Cell Phone #: _____

Date of Birth: _____

Age: _____ Gender: ☐ Male ☐ Female

Social Security #: _____

Email address: _____

Preferred Pharmacy: _____

Ethnicity: Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) ☐ Yes ☐ No

Race:
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian
- ☐ White or Caucasian

Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Work Status: ☐ Working ☐ Unemployed ☐ Retired ☐ Disabled ☐ On leave ☐ Student

Occupation: _____

Employer: _____

Employer Phone #: _____

Who is your Primary Care Physician (PCP)?

_____

Phone #: _____

Referring Doctor: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name: _____

Insured Name: _____

Insured's Date of Birth: _____

Relationship to Insured: _____

Contract Number: _____

Group Number: _____

Specialist co-pay: $_____

SECONDARY INSURANCE

Insurance Name: _____

Insured Name: _____

Relationship to Insured: _____

Contract Number: _____

Group Number: _____

SPOUSE, PARENT OR GUARDIAN INFORMATION

Name: _____

Phone #: _____

Date of Birth: _____

Employer: _____

Social Security #: _____

EMERGENCY CONTACT INFORMATION

Person to contact in an emergency (not living with you):

Name: _____

Phone #: _____

Relationship to you: _____

I authorize Dr. Laura A. Katz to treat my medical concerns and to bill my insurance company (if applicable) for services rendered. I authorize the release of any medical information necessary to process my medical claims. I understand that payment for medical services is my responsibility to pay should my insurance company fail to make payment for any reason. I understand that non-payment of services could lead to termination of my doctor/patient relationship.

Patient/Guardian Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:
I request payment of authorized Medicare benefits to be made to Dr. Laura A. Katz on my behalf. For any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ Date: _____

Dr. Laura A. Katz

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (<u>check all that apply</u>):

Oral Communication:

☐ Home/Cell phone: _____
- ☐ Ok to leave message with detailed info.
- ☐ Leave message with call back number only.

☐ Work Telephone: _____
- ☐ Ok to leave message with detailed info.
- ☐ Leave message with call back number only.

Written Communication:

☐ Ok to mail to home address.

☐ Ok to fax to this number: _____

☐ I permit the doctor and office staff to discuss my protected health information with and disclose any test results to the following individuals. This consent is valid until given instruction otherwise.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

As a patient in our office, your care is of utmost importance to us. We want you to know that you can reach Dr. Katz at any time of the day or night, regardless to whether the office is open or closed.
During business hours, you can call our office and a member of our staff will address any issues you have by the next business day.

If you are experiencing any issues when the office is closed or after hours, you can call the main hospital telephone number at 734-240-8400 and ask to speak with Dr. Katz. They will contact her directly and your concerns will be addressed at that time. We ask that you please do not wait to call until the office is open if you are having any problems. We also ask that you not go directly to the emergency room without attempting to contact Dr. Katz first so she may determine if this is the best option for your concerns.

We hope this helps aid in taking the best care of you and/or your family members.

_____ Date: _____
Signature

_____ Date: _____
Witness

LAURA A. KATZ, M.D., P.C.
Obstetrics & Gynecology
730 N. Macomb, P.O.B. Suite 228
Monroe, MI 48162

Notice of Privacy Practices

THIS NOTICE, WHICH IS EFFECTIVE AS OF APRIL 7TH, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The doctor and staff here at Dr. Laura A. Katz, M.D., P.C. believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes you rights concerning our use of your health information.

We will use and disclose your health information for purposes of treatment, payment and/or health care operations.

1. **Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. *For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.*
2. **Payment** means activities undertaken by a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care. *For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.*
3. **Health Care Operations** includes certain activities of the practice, as well as activities of an organized health care arrangement in which we participate, including: quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and business management and planning. *For example, from time to time hospitals and insurance companies will review physicians' clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary of the reviewer to randomly select and examine patients' medical records.*

We are permitted or required to disclose limited health information about you, *without your authorization*, in the following circumstances.

1. **As required by law so long as it is limited to the relevant requirements of such law.**
2. **For public health activities**, including the prevention of control of disease, vital statistics and public health investigations.
3. For purposes of making required reports about **victims of abuse, neglect or domestic violence.**
4. **Health oversight activities, including audits**, civil, criminal or administrative investigations, proceedings or actions; inspections; licensure or disciplinary actions.
5. **Judicial and administrative proceedings,** in response to court orders.
6. **Law enforcement purposes** (i.e., report of gunshot wounds; grand jury subpoenas; and information, regarding victims of crime).
7. **To coroners, medical examiners and funeral directors** for purposes of identifying deceased persons or determining cause of death.
8. For **organ and tissue donations,** consistent with applicable laws.
9. **Research,** provided the federal regulations governing research activities that insure the private of your health information are met.
10. To **advert serious threats** to health or safety.
11. **Specialized government functions** regarding military personnel and military veterans, certain national security purposes, and inmates.
12. **Workers' compensation** to the extent necessary to comply with applicable laws
13. **Marketing,** for purposes of appointment reminders, treatment alternatives, or other related benefits and services that may be of interest to you.

Any uses or disclosures other than those noted above require us to obtain your written authorizations, which you may revoke at any time. Any such revocation must be in writing.

You have the following rights with respect to your health information:

1. The right to request restrictions on certain uses of your health information, however we are not required to agree to your request.
2. The right to request, in writing, the manner or method by which we contact you to furnish confidential communications about your health information (i.e., fax, e-mail, voice mail, etc.). You are obligated to notify us, in writing, of any changes to your request.
3. The right to inspect your health information (you are entitled to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in, a civil, criminal, or circumstances, the right to ask us to ament your health information, however we reserve the right to deny your request. If your request to ament is denied, we will provide you with information about the basis of our denial and your right to submit a written statement disagreeing with our denial.
5. The right to receive an accounting of disclosures of your health information, except those disclosures related to treatment, payment or health operations, disclosures that are made to you, disclosures that were made prior to the compliance date.
6. The right to receive a copy of this Notice in writing.

We have the following obligations:

1. We are required by law to maintain the privacy of your health information, and we are required to provide you with a notice of our legal duties and privacy practices.
2. We are required to abide the terms of the notice.
3. We are required to advise you of any changes we make in the terms of our notice of privacy practices. If any changes are made to notice of privacy practices, we will post the revised notice and make a copy of it available on request.

Complaints

If you believe ewe have violated your privacy rights, you make file a written compliant to our Privacy Officer and/or the Secretary of Health and Human Services. There will be no retaliations for filing a complaint.

If you want more information or you believe your rights have been violated, you can contact Our Privacy Officer at the following address 740 N. Macomb St Monroe, Michigan 48162, Attention Saundra Stark. Her telephone number is 734 241 1700. Alternatively, you may wish to contact the federal agency in charge of enforcing patients' privacy rights. That address is: Office for civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHS Building, Washington, D.C. 20201.

Acknowledgement

I have read the foregoing Notice of Privacy Practices provided to me by Dr. Laura A. Katz, M.D.,P.C., and I have been given the opportunity to discuss Dr. Laura A Katz's privacy practices. I understand that Dr. Laura A. Katz may, at her discretion, change the terms and conditions of this Notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of same.

_____ _____

Print name Signature Date Staff initials

The NPP was provided to _____, however he/she did not acknowledge receipt for the following reason: refused did not understand other_____

_____ _____

Staff signature Date

Laura A. Katz, M.D., P.C.
Obstetrics & Gynecology
730 N. Macomb St. STE# 324
Monroe, MI 48162

I, _____, authorize the taking of an identification photograph during my initial consultation with Dr. Laura Katz for the purposes of medical documentation with the understanding such photograph will be kept confidential in my medical records. Initial _____

FRAGRANCE FREE OFFICE AGREEMENT: Initial _____
Due to the severe allergies in Dr. Katz/Dr. Pasko's office, I agree to refrain from wearing ANY scented products (ie: perfume, lotion, body wash, hair products, etc.) to my appointment(s). This includes anyone who accompanies me as well. If I do, I understand I will be asked to reschedule and come back at a later date for safety reasons.

CO-PAY POLICY: Initial _____
All patients who have a preset co-pay amount are required to pay that amount on the day of service. We are required by law and contract to collect from the patient any co-payments by your insurance plan on the date of service. We risk being dropped by the insurance company if co-pays are not collected as agreed upon in our participation contract. All outstanding co-pays must be paid up-to-date. If you have an outstanding balance, it is imperative that you contact the billing department or office manager to discuss payment arrangement as soon as possible.

RETURN CHECK POLICY: Initial _____
For all checks returned from the bank for non-sufficient funds, or for any reason, the following will apply: your account will be charged for the amount of your check and a $35.00 returned check handling fee. We will at that time freeze your account and no longer accept personal checks from you. All further services rendered would have to be paid by cash, Visa or MasterCard. All outstanding charges must be paid up-to-date. If you have an outstanding balance, it is imperative that you contact the billing department or office manager to discuss payment arrangement as soon as possible.

MEDICAL FORMS POLICY: Initial _____
There is a $25.00 fee per form that must be paid at the time medical forms are submitted. The charge would apply to medical forms such as any type of insurance company form or disability form. Please make us aware of urgent deadlines and we will do our best to complete the forms within the time you request. These forms will not be completed during a medical visit. We will forward the forms to the necessary party per your request or you will be notified when they are ready for pick-up.

NO SHOW POLICY: Initial _____
Failure to cancel an appointment within a timely manner will result in a $25.00 charge to you. This fee will be added to your account and will be due immediately upon receipt of notice and before your next appointment. We understand that emergencies arise; however, failure to notify our office within 24 hours that you cannot keep your appointment will be considered a 'no show'. Three 'no shows' may lead to dismissal from our practice. Also, if you are more than15 minutes late for your appointment, you will be rescheduled.

INSURANCE BILLING POLICY: Initial _____
The patient is responsible to know if the medical provider they are scheduled to see is an authorized provider according to their insurance contract. The patient's insurance contract is an agreement between the patient and the insurance company, therefore, if for any reason the insurance contract is not valid or any fees are not covered the patient is responsible for payment of all charges. It is the patient's responsibility to know about all the requirements of the insurance plan. Our 'Patient Insurance Coverage Responsibility Disclaimer' states as follows:

"I understand that it is my responsibility to know if Dr. Laura A. Katz is an authorized provider or is my assigned PCP according to my insurance contract. I realize that my insurance contract is an agreement between my insurance company and me. Therefore, if for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I also understand that Dr. Laura A. Katz is required by law and contract to collect from me, on the date of service, any deductible and/or co-payments required by my insurance contract.

I realize I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing, and referral appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialist appointments, I realize that it is my responsibility to request a referral authorization from Dr. Laura A. Katz. Failure to do so may result in your insurance company denying payment for services and you receiving a bill for services performed."

Signed: _____ **Date :** _____ **Witness:** _____

QUESTIONNAIRE
GYN

Please tell us what brought you into our office today:

1. Do you wear a seatbelt?

2. Do you wear a bike helmet?

3. Do you have smoke detectors in your home?

4. Is there a gun in your home?
   a. Is it kept in a safe place from children?
   b. Is there a 'safety' on it?

5. Do you drink alcohol?

6. Do you smoke cigarettes?
   Use any type of tobacco product?

7. Do you use any illicit/recreational drugs?
   If yes, please name the type(s):

8. Do you drink any caffeine containing products?

9. Do you exercise? If yes, how often?

10. Are you afraid of anyone or have any concerns that someone might hurt you?

11. We all fight at home. What happens when you and your partner fight or disagree?

12. Within the past year have you been hit, kicked or forced to have sex?

13. Has your partner ever prevented you from leaving the house, seeing friends, getting a job or continuing your education?

14. Are you, or have you ever been in a relationship where you are being hit or otherwise hurt or forced to have sex?

LADIES OVER 40 YEARS OF AGE:
Please tell us the last time you had the following tests done.

Pap Smear: _____ Mammogram: _____

Colonoscopy: _____ Bone Density Scan: _____

SIGN: _____ **DATE:** _____

Laura A. Katz, M.D., P.C.

730 N. Macomb St., Suite #324
Monroe, MI 48162
Office: (734) 242-5588
Fax: (734) 242-5144

As a patient in our office, your care is of utmost importance to us. We want you to know that you can reach Dr. Katz at any time of the day or night, regardless to whether the office is open or closed.

During business hours, please call our office and a member of our staff will address any issues you may be having. They will inform Dr. Katz and you will receive an answer by the next business day.

If you are experiencing any issues after hours, you can call the main hospital telephone number at 734-240-8400 and ask to speak with Dr. Katz. They should patch you through to her private cell phone and your concerns will be addressed at that time. We ask that you please **do not wait** to call until the office is open if you are **having any problems**. Please use all these options **before** going to the emergency room.

We hope this helps aid in taking the best care of you and/or your family members. Thank you for your cooperation.

Dr. Katz and Staff

NAME_____DATE_____

WITNESS_____

Laura A. Katz, M.D., P.C.

730 N. Macomb St.,Ste. 324
Monroe, MI 48162
Office: (734) 242-5588

Welcome to our office!

You have been accepted as a patient to the practice of Laura A. Katz, M.D.,P.C. based on the assumption that you have given us an accurate medical and/or pregnancy history so that we can safely care for you in this office environment.

We wish to notify you that if there are additional medical or historical details that would classify you as a more high risk patient, there is a possibility that you could be referred to another physician or a tertiary care center. We want you to receive the best care!

Thank you very much for your time, and for our pregnant patients, congratulations on your new pregnancy!

Sincerely,

Dr. Laura A. Katz and Staff

NAME_____DATE_____

WITNESS_____

Dr. Laura A. Katz

MEDICATION LIST

Name: _____ D.O.B.: _____

Drug Allergies ☐ **No Known Drug Allergy**

1.	3.	5.
2.	4.	6.

Please list all medications (prescription, over-the-counter, herbs, supplements) that you are taking and the condition or disease that you are taking these medications for.

Name of Medication	Why do you take it?	Dosing	How often is it taken?
Ex: Aspirin	*Preventative*	*81mg*	*1 pill a day*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Reviewed By:

Physician Signature	Date	Physician Signature	Date

ORIGINAL DATE:
FOR OFFICE USE ONLY
☐ NEW PATIENT
☐ ESTABLISHED PATIENT

PATIENT INTAKE HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient Name:	☐ M ☐ F	**BIRTH DATE:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Please describe what brings you into our office today:		
Name of spouse/partner:	**Emergency Contact:**	(PHONE#)
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	☐ TDap	
Last TB skin test:	☐Hepatitis	☐ Chickenpox	☐ Gardisil	☐ Polio
	☐Influenza	☐ MMR *Measles, Mumps, Rubella*	☐ BCG	

List any medical problems that other doctors have diagnosed

Surgeries (Please attach another sheet if you need more room to list – you can ask for one at the front desk)

Type	Year	Hospital

Other hospitalizations

Reason	Year	Hospital

PHYSICIAN'S NOTES:

PATIENT INTAKE HISTORY (Continued)		
PATIENT NAME:	DOB:	TODAY'S DATE:

OBSTETRIC HISTORY (PLEASE GIVE DETAILS ABOUT MISCARRIAGES/ABORTIONS IN COMMENTS AREA)

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37WKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY	COMPLICATIONS?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

COMMENTS:

GYNECOLOGICAL HISTORY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination? If yes, describe:	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual moodiness, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap?	Have you ever had an abnormal pap result?	

OTHER GENERAL HEALTH ISSUES

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal/Bowel	☐ Energy level
☐ Eyes (Wear glasses?)	☐ Bladder	☐ Ability to sleep
☐ Nose	☐ Muscle or Joint Pain?	☐ Other pain/discomfort:
☐ Throat/Lungs	☐ Circulation/Bruising	

Have you ever had a blood transfusion?	☐ Yes	☐ No

PATIENT INTAKE HISTORY (Continued)		
PATIENT NAME:	DOB:	TODAY'S DATE:

FAMILY HEALTH HISTORY

PLEASE INDICATE WHICH FAMLY MEMBER HAS HAD ANY OF THE FOLLOWING PROBLEMS
(INCLUDE MOM, DAD, SIBLINGS, CHILDREN, MATERNAL/PATERNAL GRANDPARENTS, AUNTS, UNCLES, COUSINS, ETC.)

ILLNESS	YES	WHICH RELATIVE(S)	PHYSICIAN'S NOTES
DIABETES			
STROKE			
HEART DISEASE			
BLOOD CLOTS IN LUNGS/LEGS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
HEPATITIS			
HIV/AIDS			
TUBERCULOSIS			
BIRTH DEFECTS			
DRUG/ALCOHOL PROBLEMS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
MENTAL ILLNESS/DEPRESSION			
ALZHEIMER'S DISEASE			
OTHER			

PERSONAL PAST HISTORY OF ILLNESSES

(Include any chronic illness you have ever taken medication for and please add below if condition not listed)

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ANEMIA				
ASTHMA/PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
SEXUALLY TRANSMITTED DISEASE				
HEART ATTACK/PROBLEMS				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS/LEGS				
EATING DISORDERS				
LUPUS				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
GLAUCOMA/CATARACTS				
BROKEN BONES				
THYROID DISEASE				
HEPATITIS/JAUNDICE/LIVER DISEASE				
SEIZURES/CONVULSIONS/EPILEPSY				
ARTHRITIS/JOINT PAIN/BACK PAIN				

PATIENT INTAKE HISTORY (Continued)		
PATIENT NAME:	DOB:	TODAY'S DATE:

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you find yourself not enjoying things in your life like you used to?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Is there anything that makes you happy?	☐ Yes	☐ No
Have you ever been to a counselor or psychiatrist?	☐ Yes	☐ No

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day:	# of snacks you eat in a day:			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active? If yes, how many partners in your lifetime? _____			☐ Yes	☐ No
	Sexual orientation: ☐ Heterosexual (male partner) ☐ Homosexual (female partner) ☐ Bisexual (male & female partners)				
	List present method of birth control:				
	Any discomfort with intercourse?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No

NAME: _____

DATE: _____

THE BLADDER HEALTH QUESTIONNAIRE

INSTRUCTIONS: Bladder problems can affect the way we live. These problems can include frequent visits to the bathroom, a sudden or strong urge to urinate, accidental loss of urine, blood in your urine, and pain with urination. Please take a minute to answer the questions below about the past 4 weeks by **circling** the best response. For questions 1 through 5, write in the number you circle for each question in the box labeled "score". Once you have completed the questionnaire, add your score for questions 1 through 5. The TOTAL score will help you and your healthcare professional decide how serious your bladder problems may be.

Please answer **YES** or **NO** to the following questions **A** and **B**.

A. Have you noticed any blood in your urine or "pink" urine? **NO** **YES**

B. Did you have pain with urination? **NO** **YES**

If you answered "yes" to A or B, we recommend that you seek medical attention immediately.
If you answered "no" to both questions, please continue.

How often in the past 4 weeks.....	Not a problem	Less than once a week	About 1 to 2 days a week	About 3 to 4 days a week	5 or more days per week	SCORE
1. ...did you wake up at night to urinate 2 or more times?	0	5	10	15	20	
2. ...did you have a sudden and uncomfortable feeling you had to urinate soon?	0	5	10	15	20	
3. ...were you bothered or concerned about bladder control?	0	5	10	15	20	
4. ...did you lose or leak urine for any reason?	0	5	10	15	20	
5. ...did you wear a pad or other material to absorb urine you may have lost?	0	5	10	15	20	
					TOTAL	

If your score is over 60, you may **very likely benefit from care or treatment.**
If your score is between 21 and 60, you may **probably benefit from care or treatment.**
If your score is less than 21, you are **less likely to need treatment.**

PLEASE DISCUSS THESE RESULTS WITH YOUR HEALTHCARE PROFESSIONAL. Only a healthcare professional can evaluate or diagnose your bladder health. Effective treatment is available for almost all bladder problems.

Name: _____

DOB: _____

Date: _____

NIDA Drug Screening Tool

Quick Screen

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Tobacco Products

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Illegal Drugs

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

riscover® cancer compass

Does cancer run in your family? Answer these questions about biological (blood) relatives on both sides of your family:

PARENTS
BROTHERS & SISTERS
HALF SIBLINGS
CHILDREN
GRANDCHILDREN
GRANDPARENTS
AUNTS & UNCLES
NIECES & NEPHEWS

PATIENT NAME _____

DATE OF BIRTH *(mm/dd/yyyy)* _____

TODAY'S DATE *(mm/dd/yy)* _____

1 *Have you or any of your relatives had* BREAST CANCER?

NO ☐ YES ☐ →

N ☐ Y ☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*
◯ **BREAST CANCER** ◯ **PANCREATIC CANCER** ◯ **PROSTATE CANCER**

N ☐ ☐ Do you have any grandparents who are Ashkenazi Jewish?

Have you or any of your relatives been diagnosed with:

N ☐ ☐ Breast cancer at age 45 or younger?
N ☐ ☐ Male breast cancer?
N ☐ ☐ Triple negative breast cancer at age 60 or younger?
N ☐ ☐ Two different breast cancers, with the first diagnosed at age 50 or younger?

these are rare

If YES to any, fill out the other side of this form.

2 *Have you or any of your relatives had* LYNCH SYNDROME-RELATED CANCERS? *(see list at right)*

NO ☐ YES ☐ →

N ☐ Y ☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*

LYNCH SYNDROME-RELATED CANCERS

◯ **COLORECTAL CANCER** ◯ **SMALL BOWEL CANCER** ◯ **URETER CANCER**
◯ **UTERINE CANCER** ◯ **BILIARY TRACT CANCER** ◯ **BRAIN TUMORS**
◯ **STOMACH CANCER** ◯ **KIDNEY CANCER** ◯ **PANCREATIC CANCER**

N ☐ ☐ Have you or any of your close relatives (parents, children, siblings) been diagnosed with colorectal or uterine cancer at age 49 or younger?

N ☐ ☐ Have you or any of your relatives been diagnosed with two different types of Lynch syndrome-related cancers (in the same person)?

If YES to any, fill out the other side of this form.

3 *Have you or any of your relatives had* OVARIAN, FALLOPIAN TUBE, *or* PERITONEAL CANCER?

NO ☐ YES ☐ →

If YES, fill out the other side of this form.

If you answered **NO** to all the questions, you don't need to fill out the other side.

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Are **outlined** questions checked on front side?
☐ Yes → Turn to other side and count the cancers.
☐ No

Are ☐ questions checked on front or back side?
☐ Yes → Patient likely meets NCCN criteria. → Patient accepted testing?
☐ No

☐ Yes Date drawn: _____
☐ No

progenity® Prepare for life.

CANCER FAMILY HISTORY

riscover® cancer compass

PATIENT NAME _____

DATE OF BIRTH *(mm/dd/yyyy)* _____

Complete this side if you have relatives with these cancers only

- ○ BREAST
- ○ PANCREATIC
- ○ PROSTATE
- ○ OVARIAN
- ○ FALLOPIAN TUBE
- ○ PERITONEAL
- ○ LYNCH SYNDROME-RELATED CANCERS: COLORECTAL, UTERINE, STOMACH, SMALL BOWEL, BILIARY TRACT, KIDNEY, URETER, BRAIN TUMORS

If you have more affected relatives, use the "other" space in each category.

***AVAILABLE TO TEST?**

Tell us if affected relatives are available for testing by writing the appropriate letter code in the box.

N Unavailable due to personal reasons
D Deceased
E Estranged; unable to contact
Y Available for testing

Some health plans require this information to determine eligibility.

Relatives on your mother's side

MOTHER
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

MATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

MATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

MATERNAL GRANDMOTHER
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

MATERNAL GRANDFATHER
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ PROSTATE

OTHER MATERNAL *relationship:* _____
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

Relatives on your father's side

FATHER
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ PROSTATE

PATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

PATERNAL AUNT/UNCLE
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

PATERNAL GRANDMOTHER
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

PATERNAL GRANDFATHER
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ PROSTATE

OTHER PATERNAL *relationship:* _____
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

Relatives that belong to both your mother's and father's sides

YOU
☐ Female ☐ Male
Age diagnosed: _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR CHILD
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR GRANDCHILD
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR SIBLING
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR NIECE/NEPHEW
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

OTHER *relationship:* _____
☐ Female ☐ Male
Age diagnosed: _____
Available to test?* _____
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

OFFICE USE ONLY

If outlined questions are checked on the front, count the affected relatives on the **same side of the family.**

Relatives in the bottom category (**YOU, YOUR SIBLING, etc.**) count on **both sides of the family.**

N ☐ ■ 3 people on the **same side of the family** with ☑**BREAST,** ☑**PANCREATIC,** or ☑**PROSTATE CANCER?**

N ☐ ■ 2 people on the **same side of the family** with ☑**BREAST,** ☑**PANCREATIC,** or ☑**PROSTATE CANCER,** with one person diagnosed with breast cancer at age 50 or younger?

N ☐ ■ 3 people on the **same side of the family** with ☑**LYNCH-RELATED** or ☑**PANCREATIC CANCER?**

N ☐ ■ 2 people on the **same side of the family** with ☑**LYNCH-RELATED** or ☑**PANCREATIC CANCER** with one person diagnosed at age 49 or younger?