CARROLL COUNTY GENERAL HEALTH DISTRICT
301 Moody Avenue, S.W., P. O. Box 98
Carrollton, Ohio 44615

Public Health
Prevent. Promote. Protect.

Medical History Update

NAME_____**DATE**_____**ALLERGIES**_____

Medications/Herbs/Vitamins _____ **Recent Changes in Family Medical History?**_____

In the past 12 months: Hospitalized_____Surgery_____Major Illness_____

Current Birth Control Method_____**Any Problems**_____**Desire Different Method**_____

Number of sexual partners in the past 12 months_____**Length** of time with current partner_____

New problems or questions for us?_____

_____

Check any symptoms as they apply to you:

GENERAL
___Chills
___Fever
___Sweats
___Dizziness/Fainting
___Headaches
___Change in sleep pattern
___Numbness/Pain
___ Skin (rash/bruise/sores/mole change)
___Other

GASTROINTESTINAL
___Poor appetite
___Bloating
___Constipation
___Diarrhea
___Nausea/Vomiting
___Indigestion
___Excessive thirst
___Hemorrhoids
___Stomach Pain

EYES, EARS, NOSE, AND THROAT
___Bleeding gums
___Difficulty swallowing
___Hoarseness
___Sinus problems
___Nosebleeds
___Ringing in the ears
___Persistent cough
___Earaches/discharge
___Blurry vision/vision changes

GENITO-URINARY
___Blood in urine
___Frequent urination
___Painful urination
___Lack of bladder control

CARDIOVASCULAR
___Chest pain
___Irregular heartbeat
___Various Veins
___Shortness of breath

REPRODUCTIVE
___Breast Lump
___Nipple Discharge
___Irregular Bleeding
___Vaginal Discharge

Are you up to date on your immunizations?

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Notice of Privacy Practices Acknowledgement Cover Sheet

The Notice of Privacy Practices describes how we may use and disclose your medical information. The Notice of Privacy Practices also describes your rights in regard to your medical information and how you can access this information.

I, _____, agree that I have received this Notice

of Privacy Practices.

_____ _____
Client or Client Guardian Signature **Date**

I accept a copy_____
(I would like to take a copy with me)

--OR--

I decline a copy_____
(I do not wish to take a copy with me)

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PSYCHOSOCIAL QUESTIONNAIRE

Your emotional and social health is just as important as your physical health. Please answer the following questions and know that your answers are confidential. If the nurse or physician feels that you are in need of further services, a referral may be offered to you (if you are a minor and the nurse/physician feels that you are in danger, a referral will be made to Child Protective Services).

Do you smoke? No☐ Yes☐ How many cigarettes per day?______________________

Do you drink alcohol? No☐ Yes☐ How many drinks?______How often?_________

Do you use street drugs? No☐ Yes☐ What type?______How often?______________

Do you ever use prescription or over the counter drugs to get high? No☐ Yes☐ What type? ______________How often?____

Do you ever forget things you did while using alcohol or drugs? No☐ Yes☐

Are you in a relationship (partner/family member/other) in which you have been physically hurt or threatened? No☐ Yes☐____

Do you ever feel afraid or threatened by your partner/family member/other? No☐ Yes☐

Do you feelings of depressed mood/lack of energy/feelings of guilt or worthlessness/trouble sleeping/sleeping too much/thoughts of suicide? *(Please circle)*

Have you ever been pressured or forced to have sex? No☐ Yes☐

Have you ever had sex to get money or drugs? No☐ Yes☐

Are you aware that the safest type of sex is no sex? No☐ Yes☐

Is your family aware that you are a client at our clinic? No☐ Yes☐

Is there anything else you would like us to know?____

Signature____Date_____________________

♦♦

Nurse:

☐Reviewed sexual coercion (Minors)

☐Encouraged family involvement (Minors)

☐Encouraged abstinence/client has received educational pamphlet (Minors)

☐Other____

❐ Referred to____Date/Time____________________

Nurse Signature____Date__________________________

CARROLL COUNTY GENERAL HEALTH DISTRICT
REPRODUCTIVE LIFE PLAN

Name: _____ **Date:** _____

Do you want to have children one day? ☐ **Yes** ☐ **No**

If yes:

At what age you would like to have children? _____

How many children would you like? _____

How far apart would you like your children to be? _____

Are you now using birth control method? ☐ Yes ☐ No

If no:

What will you do if you do become pregnant? _____

- I have children (List Boy/Girl andBirth year)_____

Personal Habits

Do you smoke? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No

If yes, how much? _____

Are you having sex with more than one partner/person? ☐ Yes ☐ No

Do you sometimes go on unhealthy diets or overeat? ☐ Yes ☐ No

Do you use street drugs or prescription drugs for fun? ☐ Yes ☐ No

Emotional Health

When you feel sad do you bounce back quickly or feel sad for 2 weeks or more? _____

How often do you feel nervous, anxious, or worried? _____

How do you calm yourself down if you are angry? _____

Is there anyone in your life who physically hurts you? ☐ Yes ☐ No

Is there anyone in your life who often says hurtful or mean things? ☐ Yes ☐ No

Important Vaccinations – Check vaccinations you have received:

- ☐ Tetanus
- ☐ Hepatitis
- ☐ Hepatitis B
- ☐ Gardasil
- ☐ Varicella (chicken pox)
- ☐ Measles, Mumps, Rubella
- ☐ Inactivated Polio Virus
- ☐ Pertussis (whooping cough)

Family History – Check those which have happened in your immediate family:

- ☐ A baby born too soon or weighing less than 5 ½ lbs
- ☐ High blood pressure in pregnancy
- ☐ Diabetes in pregnancy
- ☐ Two or more miscarriages
- ☐ Stillborn baby
- ☐ Stroke
- ☐ Asthma
- ☐ Heart or Lung Disease

☐ Baby with a heart defect ☐ Other:

Personal Goals:

I will take a daily multivitamin or prenatal vitamin with folic acid. ☐

I will start exercising or exercise more often. ☐

I will **quit** smoking or **smoke less**. ☐

I will **increase** or **always** use condoms when having sex. ☐

I will **quit** or **decrease** the amount of alcohol or drugs I use. ☐

I will **increase**, **maintain** or **reduce** my weight. ☐

I will not get pregnant until I am ready by not having sex or by always using birth control. ☐

Other:_____

Professional Goals:

_____

_____

More Information Provided About:

☐ Birth Control Methods ☐ Physical Abuse ☐ Overeating

☐ Smoke Cessation ☐ Emotional Abuse ☐ Vaccinations

☐ Alcohol Abuse ☐ Anxiety and Stress ☐ Drug Abuse

☐Unhealthy Dieting ☐ Sexually Transmitted Diseases

RLP Updated___Date_____
RLP Updated___Date_____
RLP Updated___Date_____

Copy to Client

Carroll County Reproductive Health Clinic is funded by the Ohio Dept of Health Title X Grant

Financial Information Form

Name (Please Print) _____

Social Security #: _____ Date of Birth ____/____/____

Your photo I.D. and Medicaid or Insurance card MUST be presented at each visit.

PLEASE COMPLETE ONE OF THE FOLLOWING BOXES AND SIGN BELOW

☐ I do **NOT** wish to apply for reduced fees at this time. I will pay 100% of my fees with cash, check, or money order.

☐ I have an Ohio Medicaid card: _____

☐ I belong to a Medicaid HMO: ☐ Care Source ☐ Buckeye ☐ United Healthcare

☐ **I have _____ Insurance** Group ID _____ Group # _____

_____

If insurance is not under your name, what is the name and relationship of the person with the insurance?

_____

Social Security # of the Insured _____ Date of Birth of the Insured ____/____/____

Address of the Insured _____

☐ I would like to apply for reduced fees. Number of people supported by family income (household size) _____

(Please record all that apply for your household)

☐ I am 17 years old or younger and need confidential services. Please calculate my fees based on my income only.

☐ I am in College or Vocational School and receive the following funds for my living expenses:

Parents $ _____ Other $ _____ per month

☐ My hourly wage is $ _____ I work _____ hours per week

I have the following additional income:

☐ Alimony _____ ☐ Unemployment _____ Other _____

☐ Tips _____ ☐ Social Security _____

The amount of income is: $ _____ per ☐ week ☐ month ☐ year

☐ I live with my spouse/partner/parents who earn $ _____ per hour. They work _____ hours per week.

certify the above information is accurate and complete. I am responsible for the fees listed on my bill statement

Patient's Signature: _____ **Today's Date:** ____/____/____

For Office Use Only- Required For All Patients Weekly Income: $ _____

Fee Category: (circle one) 0 20 30 40 60 80 Full Medicaid/Medicaid HMO Private Ins

Verified By: _____ Today's Date: ____/____/____

NO PATIENT WILL BE DENIED SERVICE DUE TO INABILITY TO PAY

The Carroll County Health Department offers reproductive health services to women and men. A fee schedule for services is available upon request from the Nursing Division.

Fees for services are based on your household income and family size. **Please bring proof of your income when you arrive for your visit.** Until proof of income is evaluated, it will be presumed that you will be responsible for 100% of your charges.

All charges determined to be “patient responsibility” are expected at the time of service. Medicaid, Unison, Buckeye and Care Source Managed Medicaid Programs are accepted. Currently there are no co-pays associated with these programs.

If you are at 0%, donations are welcome and appreciated at the time of your visit. Your donations help keep our doors open and continue to provide discounted healthcare services.

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