

PARTNERSHIP HEALTH CENTER

PATIENT INFORMATION: (Who is being seen today)

Last Name: _____ First Name: _____ Middle Initial: _____
 Address: _____ SSN: ____ / ____ / ____ Date of Birth: ____ / ____ / ____
 _____ Sex: Male Female
 City: _____ State: _____ Zip Code: _____
 Phone#: _____ Driver's License: _____
 Marital Status: Single Single w/Partner Married Separated Divorced Widowed
 Employment Status: Full-Time Part-Time Unemployed Retired
 Employer: _____ Work Phone#: _____
 Are you a Student? Yes No (If yes: Full-Time or Part-Time)
 Are you a Veteran? Yes No
 Which Ethnic Group do you feel you belong to? American Indian Black Hispanic Asian
 White Other
 Relationship to Responsible Party? _____
 What County do you live in? _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL:

Last Name: _____ First Name: _____ Middle Initial: _____
 SSN: ____ / ____ / ____ Date of Birth: ____ / ____ / ____ Sex: Male Female
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone#: _____ Message Phone#: _____ Can we call you? Yes No
 Employment Status: Full-Time Part-Time Unemployed Retired
 Employer: _____ Work Phone#: _____
 Are you Homeless? Yes No If yes, for how long have you been homeless?
 If yes, where do you live? Street Shelter Doubling up Transition Other
 Which Ethnic Group do you feel you belong to? American Indian Black Hispanic Asian
 White Other
 Primary Language _____ Emergency Contact Name: _____
 Emergency Contact Phone#: _____
 Do you want to apply for out sliding fee discount? Yes No Family Size: _____

PATIENT/HOUSEHOLD MEMBERS INFORMATION:

Last Name, First Name, Middle	Relationship	Birth Date	SSN	Sex	Ethnic Group	Insurance

INSURANCE COVERAGE: Must have all insurance cards front and back.Check all that apply: None Medicaid Medicare Private Insurance Blue Chip Indian Health Center VA

Primary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Secondary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	

**PARTNERSHIP HEALTH CENTER
323 WEST ALDER STREET
MISSOULA, MT 59802**

AUTHORIZATION AND ASSIGNMENT

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement for Partnership Health Center (PHC).

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. Also, I authorize PHC to bill my insurance and release information to the insurance company if requested.

Signed _____ Date _____

FOR PHC USE: STAFF INITIALS

DATE:

SLIDING SCALE: A B C D E NONE

FINANCIAL STATUS WORKSHEET**VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)**

Family Income	Yes	No
Wages		
Self Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Food Stamps		
Child Support		
Alimony		
Other (please indicate)		

TOTAL GROSS INCOME: _____

PARTNERSHIP HEALTH CENTER

Patient Name: _____

Date: _____

HEALTH HISTORY

PAST HEALTH PROBLEMS

Please indicate if you have experienced any of the following health problems

<u>Illness</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Glaucoma	_____	_____	Hemorrhoids	_____	_____
Cataracts	_____	_____	Kidney or Bladder	_____	_____
Ear Trouble	_____	_____	Prostrate	_____	_____
Deafness	_____	_____	Headaches/Migraines	_____	_____
Thyroid Trouble	_____	_____	Head Injury	_____	_____
Bronchitis	_____	_____	Stroke	_____	_____
Emphysema	_____	_____	Convulsions/Seizures	_____	_____
Pneumonia	_____	_____	Arthritis	_____	_____
Hay Fever	_____	_____	Gout	_____	_____
Asthma	_____	_____	Psoriasis	_____	_____
Tuberculosis	_____	_____	Eczema	_____	_____
High Blood Pressure	_____	_____	Cancer/Tumor	_____	_____
Heart Attack	_____	_____	Anemia	_____	_____
Hardening of Arteries	_____	_____	Bleeding Tendency	_____	_____
Heart Murmurs	_____	_____	Blood Transfusion	_____	_____
High Cholesterol	_____	_____	Diabetes	_____	_____
Ulcer	_____	_____	Polio	_____	_____
Bowel Problems	_____	_____	Depression	_____	_____
Hepatitis	_____	_____	Dental Problems	_____	_____
Gall Bladder	_____	_____	OTHER _____		
Mental Health Problems	_____	_____	_____		
Alcoholism/Drug Problems	_____	_____	_____		

MEDICATIONS: _____

MEDICATION ALLERGIES:

HEALTH BEHAVIORS

Tobacco Use? Yes ___ No ___
 # Packs Per Day ___
 # Years ___

Alcohol/Drug Use? Yes ___ No ___
 Amount Per Day ___
 Days Per Week ___

Do you use your seatbelt regularly?
 Yes ___ No ___

Do you exercise regularly
 Yes ___ No ___

Do you brush your teeth? Yes ___ No ___ Floss your teeth? Yes ___ No ___ Last Dental Visit _____

HOSPITALIZATIONS/SURGERIES

<u>Year</u>	<u>Reason</u>	<u>Hospital and City</u>

HEALTH PROBLEMS IN THE LAST YEAR (Check YES or NO if known. Leave blank if unknown.)

GENERAL	YES	NO	GENERAL	YES	NO
Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Blood in vomit	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps while walking	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by heat or cold	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Breathless at night	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Breathless with walking	<input type="checkbox"/>	<input type="checkbox"/>	Occasionally lose urine and get wet	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations / irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Pass urine more than twice at night	<input type="checkbox"/>	<input type="checkbox"/>
Change in sleep	<input type="checkbox"/>	<input type="checkbox"/>	Problems with memory	<input type="checkbox"/>	<input type="checkbox"/>
Change in walking	<input type="checkbox"/>	<input type="checkbox"/>	Shaking or trembling in hands	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain / discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (rash, itch)	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sleeps sitting up	<input type="checkbox"/>	<input type="checkbox"/>
Cough / phlegm most days	<input type="checkbox"/>	<input type="checkbox"/>	Soiling from bowels	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
Decreased energy	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs / feet	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection history	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Visual Loss	<input type="checkbox"/>	<input type="checkbox"/>
Easily Bleeds / bruises	<input type="checkbox"/>	<input type="checkbox"/>	Weakness on one side of body	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or passing out	<input type="checkbox"/>	<input type="checkbox"/>	Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Falls	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HEALTH HISTORY

Have any **immediate** family members had any of the following illnesses? If so, please indicate relationship (mother, father, sister, grandparents, children)

<u>Illness</u>	<u>Family Members</u>
High Blood Pressure	_____
Heart Disease	_____
Stroke	_____
Cancer	_____
Diabetes	_____
Asthma/Emphysema	_____
Tuberculosis	_____
Cystic Fibrosis	_____
Blood Disease	_____
Multiple Sclerosis	_____

<u>Illness</u>	<u>Family Members</u>
Epilepsy	_____
Rheumatoid Arthritis	_____
Gallbladder Disease	_____
Colitis/Irritable Bowel	_____
Migraine Headaches	_____
Mental Health Problems	_____
Depression	_____
Suicide	_____
Alcoholism	_____
Other	_____

GYNECOLOGICAL HISTORY

1. **Menstruation**

What was the age at which you began your periods? _____

Date of last menstrual period. _____

How long does your period last? _____

How often are your periods? _____

Are your menstrual periods regular? Yes _____ No _____

Do you use pads or tampons _____

Do you have painful periods Yes _____ No _____

Do you have bleeding between periods Yes _____ No _____

Do you think you may be pregnant? Yes _____ No _____

2. **Other Gynecological Issues**

Do you have any discharge from your nipples? Yes _____ No _____

Have your breasts recently changed in size? Yes _____ No _____

Do you examine your breasts monthly? Yes _____ No _____

Have you ever had a mammogram? Yes _____ No _____

Do you have hot flashes? Yes _____ No _____

Have you ever taken estrogen or other hormones? Yes _____ No _____

Have you ever had an abnormal pap? Yes _____ No _____

If Yes: Date _____

What follow-up did you have? _____

What was the date of your last pap smear? _____

Do you have problems holding your urine? Yes _____ No _____

3. **STD Information**

Do you have any unusual vaginal burning, discharge itching or burning with urination? Yes _____ No _____

Do you have any abdominal pain or painful intercourse? Yes _____ No _____

Number of sexual partners in the last year _____

Have you ever had a pelvic infection Yes _____ No _____

