### Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your “medication history.” This list is collected from a variety of sources, including your pharmacy and your health insurer.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

- [ ] I give my permission to obtain my medication history from my pharmacy, health plans and other healthcare providers
- [ ] I do not give my permission to obtain this information at this time

### HealthInfoNet Participation

Maine Family Planning participates in HealthInfoNet. While we may look at your records from other providers but we do not share your records from here with other providers. I understand MFP participates with HealthInfoNet and I have been given the opt-out form if I wish to not participate. Please Initial ____________

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**Patient Signature**

**Today’s Date**
ASSIGNMENT AND RELEASE FOR OPEN DOOR HEALTH CARE

If you have medical insurance, please review and sign the following statement:

- My signature below authorizes Maine Family Planning to bill my insurance and receive payment from them for services given to me by Maine Family Planning.
- I understand that I am financially responsible for all charges not paid by insurance.
- I authorize the use of this signature on all my insurance submissions.
- I authorize the Maine Family Planning to release my health care information, to the extent necessary, to my insurance carriers and their reviewers or others paying for this care.
- Charges for the labwork ordered by us will be billed by the lab to my private insurance, Medicaid/Medicare but if there is a remaining amount after insurance processing, I will be billed directly by the lab and that I am responsible for these charges.
- I agree to pay any insurance co-pays at the time of service. I acknowledge that I am responsible for deductibles, coinsurance and charges not covered by insurance and those charges must be paid in full within 30 days or by my next appointment, whichever is sooner.
- I understand that for Medicaid, Medicare or Private Insurance to be billed, I MUST present a current insurance card at every visit.

  - Name of Policy Holder ______________________________
  - Relationship to Policy Holder ___________________________

If you don’t have medical insurance:

- I understand that payment for services at Maine Family Planning is due in full at time of service.
- I understand that all lab orders can be sent to a lab of my choice and I will be billed directly by them for any testing and that I am responsible for those charges.

Everyone, please sign below:

Acknowledgement of receipt of Notice of Health Information Privacy Policies

- I hereby acknowledge that I have been given/offered the Maine Family Planning NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES.
- (Optional): I request that the following covered entities not have access to my private health care information without my written consent:

  ________________________________________________
  ________________________________

Signature: ________________________________ Print Name: ________________________________

Date: ____/____/____
Health History- Please complete and bring with you unless you do your history on your portal.

Name: ____________________________ Date of Birth: _______________________

- Which pharmacy do you usually use for prescriptions? __________________________ Location? __________________________
- Do you have another health care provider besides us?  □ no  □ If yes, who: __________________________

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<thead>
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<tbody>
<tr>
<td>□ no known med allergies</td>
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</tbody>
</table>

- Reaction to that medication: __________________________

- Other allergies: __________________________

- What medications do you take regularly?

<table>
<thead>
<tr>
<th>Medication/vitamin/supplement</th>
<th>Dose/strength (ie mg/pill)</th>
<th>How many times a day</th>
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Vaccinations
- HPV vaccine (Gardasil) for people under 45 yrs old
  □ All done  □ had part of series  □ have not had  □ don't know  □ might be interested

Family History: Who in your family has any of these problems and at what age did they get it if you know.

<table>
<thead>
<tr>
<th>Has no health problems</th>
<th>Age</th>
<th>Age</th>
<th>Age</th>
<th>Age</th>
<th>Bleeding too easily</th>
<th>Age</th>
<th>Age</th>
<th>Age</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood clotting disorder</td>
<td>Age</td>
<td>Age</td>
<td>Age</td>
<td>Age</td>
<td>Cancer: type</td>
<td>Age</td>
<td>Age</td>
<td>Age</td>
<td>Age</td>
</tr>
</tbody>
</table>

About you, your family, your life

We know some of these are very personal. You don't have to answer them if you are uncomfortable doing so.

Tobacco use-ever  □ Smoker □ chewer?  □ now □ past □ never  If now, how much?_____  For how long?_____
Want help quitting?  □ yes  □ no
What sex were you assigned at birth? ............ □ female  □ male
What is your current gender identity? .......... □ female  □ male  □ Transwoman/transfemale/F-M
  □ Transman/trans male/F-M  □ Genderqueer/gender non-conforming  □ Intersex  □ other: __________
By what name would you like to be called? __________________________
Personal pronouns to describe yourself:  □ she, her, hers  □ he, him, his  □ they, them, theirs  □ Other: __________
Your occupation__________________________
In school now?  □ yes  □ no  Highest grade completed ___
Are you:  □ single  □ married  □ divorced  □ separated  □ widowed  □ with a domestic partner
Number of children: ______  Ages: __________
Whom do you live with?  □ parents  □ partner /spouse  □ at school  □ friends  □ on your own  □ your kids
  □ couch surfing  □ in a shelter  □ homeless  □ other, __________
Interests/Hobbies: __________________________
Life going well in general for you? ............ □ yes  □ no
Do you need any help from us in finding help or counseling for any problems or issues?  □ yes  □ no
Usual alcohol use _____ drinks a day _______ drinks a week
About your sexual history
Are you attracted to: (check all that apply) □ men □ women □ M-F □ F-M □ other __________

How do you describe your sexual orientation? □ Straight □ Gay/Lesbian □ Bisexual □ Asexual □ Other

Ever had sex? □ no □ yes, If yes, how many sexual partners have you ever had? ______

Were they □ male □ female □ M-F transgender □ F-M transgender □ other

Teens under 18... About your parents...

If you are having sex, do they know? …………………………………… □ no □ yes

Do they know you are coming to clinic? …………………………………… □ no □ yes

Can you talk to them about personal things in your life? …… □ no □ yes

Contraception

What if, anything, are you using or doing to prevent pregnancy when you have sex?

☐ I am on a birth control method (type) __________

☐ my partner uses birth control □ condoms □ withdrawal □ tubal ligation (tubes tied) □ vasectomy

☐ trying for pregnancy □ not using anything □ my partners have the same type of genitals as I do

☐ not having sex

Interested in a different birth control? □ No □ Maybe □ Yes, I want __________

Health History: Please check off any of these that apply to you now or in the past.

<table>
<thead>
<tr>
<th>Headaches: □ frequent □ severe □ migraines</th>
<th>Eating disorder □ Significant weight gain □ loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Headaches with sparkles, spots or vision changes</td>
<td>☐ About risks/concerns- have you:</td>
</tr>
<tr>
<td>☐ Epilepsy/seizures</td>
<td>□ Had sex for money drugs or safety</td>
</tr>
<tr>
<td>□ Diabetes □ Cancer, type: __________ when?</td>
<td>□ Had sex with someone with HIV/AIDS □ hepatitis B/C</td>
</tr>
<tr>
<td>□ Thyroid lump/enlargement or □ overactive □ underactive thyroid</td>
<td>□ Substance abuse problems □ alcohol □ other</td>
</tr>
<tr>
<td>□ Heart attack □ murmur □ other heart problems</td>
<td>□ Shared needles □ Had a partner who did</td>
</tr>
<tr>
<td>□ High blood pressure □ high cholesterol</td>
<td>□ Been forced to have sex or sexually abused?</td>
</tr>
<tr>
<td>□ Bleeding disorder □ blood clotting disorder (not related to periods)</td>
<td>☐ Yes, if, yes is this still affecting you now? □ Yes □ No</td>
</tr>
<tr>
<td>□ Blood clot in □ lung □ leg □ brain/stroke</td>
<td></td>
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<tr>
<td>□ Asthma or other lung problems</td>
<td></td>
</tr>
<tr>
<td>□ Stomach/intestinal problems □ gall bladder problems</td>
<td></td>
</tr>
<tr>
<td>□ Hepatitis or other liver problems</td>
<td>People assigned as female at birth</td>
</tr>
<tr>
<td>□ Bladder infec/UTI/ other bladder/kidney pros □ incontinence</td>
<td>□ Breast cancer</td>
</tr>
<tr>
<td>□ Chlamydia □ gonorrhea □ genital warts/HPV</td>
<td>□ Fibroids/uterine growths □ frequent vaginal infections</td>
</tr>
<tr>
<td>□ Herpes □ syphilis □ HIV/AIDS</td>
<td>□ Have problems with pelvic exams</td>
</tr>
</tbody>
</table>

People assigned as male at birth:

<table>
<thead>
<tr>
<th>NGU (infection of urethra)</th>
<th>PCOS (polycystic ovaries)</th>
<th>Other problems with ovaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate problems</td>
<td>Pelvic infection/PID</td>
<td>Toxic shock</td>
</tr>
</tbody>
</table>

Mental health problems: □ anxiety disorder □ depression □ bipolar □ other mental health probs: __________

□ tried or seriously considered suicide □ recently □ in past

Other serious injuries, illnesses: __________

☐ None of these above items apply to me

Surgeries: ____________________________ □ none

People assigned as female at birth

<table>
<thead>
<tr>
<th>First day of your last period</th>
<th>Your age at your first period</th>
<th># of Pregnancies</th>
<th># of Births</th>
<th># of Miscarriages</th>
<th># of Abortions</th>
<th># of Living Children</th>
<th>Date when last pregnancy ended</th>
</tr>
</thead>
</table>

Date of last pap test: ________ It was □ normal □ abnormal.

Have you ever had any other abnormal pap tests? □ no □ yes, when ________?

Now breast feeding? □ no □ yes

If menopausal, when was your last period? ________

FP health hx OD 2019 6