

Medical History

- 1. Do you have a seizure disorder?
- 2. Do you have any history of metabolic disorders? (i.e diabetes, insulin resistance, or thyroid problems)?
- 3. Have you ever had blood clots in your legs or chest?
- 4. Have you ever had a mental health diagnosis?
- 5. Do you have any history of drug or alcohol abuse?
- 6. Do you have any chronic medical problems (i.e high blood pressure, asthma, hepatitis, or heart disease)?

Other: _____

Infection Screening

- 1. Have you ever had chicken pox or varicella vaccine?
- 2. Is there any exposure to tuberculosis (TB)?
- 3. Do you have any history of sexually transmitted diseases (STD) exposure?
- 4. Do you or your partner have a history of genital herpes?

Genetic Screening (Includes patient, baby's father, and anyone in either family)

- 1. Thalassemia
- 2. Neural Tube Defect
- 3. Congenital Heart Defect
- 4. Down Syndrome
- 5. Tay-Sachs
- 6. Canavan's Disease
- 7. Sickle Cell Disease or Trait
- 8. Hemophilia or Blood Disorder
- 9. Muscular Dystrophy
- 10. Cystic Fibrosis
- 11. Huntington's Chorea
- 12. Mental Handicap
- 13. Other Chromosomal Disorder
- 14. Other Birth Defect

Pregnancy Summary

_____ # of Pregnancies _____ # of Premature _____ # of Abortions _____ # of Twins/Multiples
 _____ # of Full Term _____ # of Miscarriages _____ # of Ectopic/Tubal _____ # of Living Children

Date of Delivery	Weeks at Time of Delivery	Hours of Labor	Birth Weight	Sex of Child	Type of Delivery	Epidural/Anesthesia	Doctor's Name

Y=Yes N=No

YES NO History of Pregnancy Complications

- 1. Any history of recurrent miscarriages, a stillbirth, or a placental abruption?
- 2. Any history of preterm labor or contractions?
- 3. Any history of preterm delivery <37 weeks or water breaking?
- 4. Any history of a baby that weighed less than 5 ½ pounds?
- 5. Any history of twins, triplets, or quads?
- 6. Any history of high blood pressure with pregnancy?
- 7. Any history of diabetes with pregnancy?
- 8. Any history of an ectopic/tubal pregnancy?



Physician: _____ Date: _____

Reason for Today's Visit: _____

Patient Name: _____

DOB: _____ Gender: _____

MRN: _____

CSN: _____

AFFIX LABEL HERE

HEALTH HISTORY FORM

Please List:

Allergies	Current Medications	Previous Surgery

Screening Tests:

Test	Date/Year	Normal	Abnormal	Have <u>You</u> Ever Had the Following?	
Pap Smear				<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
Mammogram				<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis/Jaundice
Bone Scan				<input type="checkbox"/> TB (Tuberculosis)	<input type="checkbox"/> Thrombophlebitis/ Blood Clots
Colon Cancer				<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sexually Transmitted Diseases
Cholesterol				<input type="checkbox"/> Asthma	<input type="checkbox"/> Any Other Serious Illness/Injury

Personal History:

Do you eat a well-balanced diet? **Y / N**

Do you drink alcohol? **Y / N**

Have you ever been treated for alcoholism? **Y / N**

Do you have a history of drug abuse? **Y / N**

Do you smoke? **Y / N**

Do you exercise? **Y / N**

Do you feel rested after sleep? **Y / N**

Have you recently experienced domestic violence or feel threatened? **Y / N**

Menstrual History:

Age first period began? _____

Cycle length? (example: 28 days) _____

Number of days of flow? _____

Date last period began? _____

Irregular periods? **Y / N**

Bleed between periods? **Y / N**

Heavy flow/clots/cramps? **Y / N**

Pregnancy History: How old were you when you had your first full term pregnancy? _____

Year of Delivery	Full Term Premature Stillborn Miscarriage Abortion C-Section Vaginal Delivery VBAC	List of Complications <i>i.e. high blood pressure, tubal pregnancy, gestational diabetes, etc.</i>	Sex of Child	Weight of Child
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Family History:

Family Member	Illnesses or Medical Conditions	Age at Death	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Who in your family (living or deceased) has or had the following:

Cancer	Other Diseases	
Breast Cancer	Birth Defects	Epilepsy
Ovarian Cancer	Heart Disease	Mental Illness
Uterine Cancer	High Blood Pressure	Intellectual Disability
Other Female Cancer	Diabetes	TB (Tuberculosis)
Colon Cancer	Sickle Cell Anemia	
Any Other Inherited Diseases: _____		

Physician: _____ Date : _____

Patient Name: _____

DOB: _____ Gender: _____

MRN: _____

CSN: _____

AFFIX LABEL HERE

CANCER FAMILY HISTORY

Please consider all relatives (listed below) from BOTH your mother's and father's side of the family, BOTH male and female: *father, mother, brothers, sisters, half-siblings, your children, grandparents, aunts, uncles, nieces, nephews, cousins.*

Circle **YES** or **NO** below:

- | | | |
|---|-----|----|
| 1) Have you had BREAST cancer at any age? | YES | NO |
| 2) Have you or any of the relatives (listed above) had BREAST cancer at age 49 or younger? | YES | NO |
| 3) Have you had THREE or more relatives (listed above and can include you) with BREAST cancer on the SAME side of the family? | YES | NO |
| 4) Were any of the relatives with BREAST cancer MALE? | YES | NO |
| 5) Have you or any of your 1st or 2nd degree female relatives had OVARIAN cancer? (parents, siblings, grandparents, aunts, children) | YES | NO |
| 6) Have you or any of your 1st degree relatives had PANCREATIC cancer? (parents, siblings, children) | YES | NO |
| 7) Have you or any of the relatives (listed above) had COLON and/or ENDOMETRIAL cancer at age 49 or younger? | YES | NO |
| 8) Have you had THREE or more relatives (can include you) with COLON or UTERINE cancer on the SAME side of the family? | YES | NO |
| 9) Have you or any of the above 1st degree male relatives had METASTATIC PROSTATE cancer? (dad, siblings, children) | YES | NO |

If you answered **YES** to **ANY** of the questions above, please **scan the QR code** to the right with your mobile device. Select your LWH physician from the dropdown list and **fill out the quiz** to the best of your ability. Once you have completed the online quiz, please check the box below.

Quiz Complete



FOR OFFICE USE ONLY

- | | | |
|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Patient Appropriate for Testing | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined |
| <input type="checkbox"/> Patient Does Not Meet Criteria | | |



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR INFORMATION

We are required to maintain the privacy of your protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). Your "protected health information" is information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present, or future physical or mental health or condition, or payment for the provision of your health care. If other federal laws or state laws provide more stringent protection for the privacy of your medical information, we will follow these other laws.

YOUR RIGHTS: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.
- We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a copy of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with us if you feel we have violated your rights by contacting our HIPAA contact person or office. We will not retaliate against you for filing a complaint.
- To file a complaint with our organization, please submit your request in writing to:

HIPAA Compliance Officer
500 Rue de la Vie, Suite 100
Baton Rouge, LA 70817
(225) 201-2000

- You can file a complaint with the U.S. Department of Health and Human Services' Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care or payment related to your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these following cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes and 42 CFR Part 2 SUD counseling notes

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

OUR USES AND DISCLOSURES: We typically use or share your health information in the following ways:

Treatment:

- We may share your information for treatment activities of another provider involved in your care.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Payment:

- We can use and share your health information to bill and get payment from health plans or other entities or individuals.
- *Example: We give information about you to your health insurance plan so it will pay for your services*

Health Care Operations:

- We may use and share your medical information for our health care operations, and to

contact you when necessary. A few examples may include using your information for:

- Improving the quality of the care we give you
 - Disease management, wellness management, or population health programs
 - Patient surveys
 - Training students
 - Business planning and administration
 - Resolving patient complaints
 - Getting or keeping an accreditation
 - Compliance and legal services
- We may also share your protected health information with people or companies (called business associates) we use to help us with our operations.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet legal requirements before we can share your information for these purposes.

- **Help with public health and safety issues**

We may share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

- **Do research**

We may use or share your information for health research.

- **Comply with the law**

We will share information about you if state or federal laws require it, and we may share it when those laws allow it. For example, if the Department of Health and Human Services wants to see that we're complying with federal privacy law.

- **Respond to organ and tissue donation requests**

We may share health information about you with organ procurement organizations.

- **Work with a medical examiner or funeral director**

We may share health information with a coroner, medical examiner, or funeral director when an individual dies.

- **Address workers' compensation, law enforcement, and other government requests**

We may use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions**

We may share health information about you in response to a court or administrative order, or in response to a subpoena.

- **Proof of Immunization**

We may disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

- **Correctional Institutions**

If you are an inmate of a correctional institution, we may disclose information necessary for your health and the health and safety of other individuals to the institution.

42 CFR PART 2 SUBSTANCE USE DISORDER RECORDS:

Part 2 SUD records are records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

Written patient consent is required for uses and disclosures of Part 2 substance use disorder records (SUDs) for treatment, payment, and healthcare operations (TPO). This consent may be on a single consent form. Non-TPO disclosures of these SUD records require separate, specific consent.

We will only use or disclose Part 2 SUD records in a civil, criminal, administrative, or legislative proceeding against you when:

- You provide written consent for such use or disclosure; or
- A court orders the use or disclosure after provision of appropriate notice and an opportunity to be heard, AND a subpoena or other legal mandate compels the disclosure.

Our Responsibilities

- We are required by law to maintain the privacy of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

Other Uses and Disclosures of Health Information

Other ways we share and use your health information not covered by this notice will be made only with your written authorization. If you authorize us to use or disclose your health information, you may cancel that authorization, in writing, at any time. However, the cancellation will not apply to information we have already used and disclosed based on the earlier authorization.

Changes to the Terms of this Notice

We may change the terms of this notice at any time and the changes will apply to all health information we have about you. The current notice will be available upon request and on our website. <https://www.lwha.com>

Patient Signature: _____