 Miami County Public Health Date: ________

Name: ____ Date of Birth: __________
First MI Last mm/dd/yy
Other Names: __________________ Minor: Yes/No Marital Status: S __ M __ D __ Widow __

Social Security Number: _____ / _____ / _________ Male/Female Age: ________

Race: Black__ White__ Hispanic__ Asian/American Indian__ Other __________________________

Address: ____
Street City State Zip

Can we mail to this address: Yes/No County of residence: ____________ Township ___________

Number of people living in residence: ______ Gross weekly income: $_______________________

Contact Number: ____________________________ Allow Text Reminders: Yes/No
(xxx) xxx-xxxx
Emergency Number: __________________________ **Allergies**: ________________
(xxx) xxx-xxxx

Current Student: Yes __ No __ Highest grade completed: ____________________
GED ________ High School Diploma ____________
College Degree ________ Some College __________

Insurance Name: _____________________ Group/Member Number: ____________________
Medicaid Number: ____________________
Buckeye/Paramount/United/CareSource/Medicaid/Molina (please circle)Number: ______________
Self Pay: _______________ Partial Pay: _____________ Donation: _________________

My signature provides consent for treatment; tests can include Chlamydia/Gonorrhea, HIV, and other tests recommended by physician, acknowledgement of notification of the Notice of Privacy Practices, verification of voluntarily participating, and verification that all information is accurate and correct to the best of my knowledge. I am aware that acceptance of family planning services is not a prerequisite to eligibility or receipt of any other service offered at Miami County Public Health. I am aware that I am responsible for the contracted price determined by insurance or by the sliding fee scale.

Signature: ____ Date: ______________

By signing my initials below, I certify that there have been no changes in the above since my last visit.

Date/Initial:	
Date/Initial:	
Date/Initial:	

Financial Information Form

Name: (Please Print): ______________________________

Social Security #: ______________ (Optional)   Date of Birth: ____________

PLEASE COMPLETE ONLY 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.

Your Medicaid or insurance card and picture I.D. MUST be presented at each visit.

☐ I have an Ohio Medicaid card : Number : ____________

☐ I belong to a Medicaid HMO: Number: ____________

- ◇ CareSource
- ◇ Buckeye
- ◇ Medicaid
- ◇ Paramount
- ◇ United Health Care Community Plan

☐ I have Private Medical Insurance with ______________________(Name of Insurance Co.)

Group ID #: ______________

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

Name: ______________   Relationship: ☐Spouse   ☐Parent/Guardian

Date of Birth of the insured: ____________

Address of the Insured: ______________________

____

____

☐ I would like to apply for reduced fees. (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.

☐ Number of people supported by family income (household size)

☐ My hourly wage is $ _____. I work ________ per week.

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

☐ I am in college or vocational school and receive the following funds for my living expenses:

Scholarships/loans $ _____ Parents $ _____ Other $ _____ per ☐quarter ☐semester

I attend ________ number of quarters/semesters a year

☐ I have the following additional income:

☐ Alimony ☐ Unemployment ☐ Tips ☐ Social Security ☐ Other

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

I certify the above information is accurate and complete.

Patient Signature: ______________________   Today's Date: ____/____/____

For Office Use Only – Required For All Patients   Weekly Income: ____________

Fee Category: ☐ Full ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Medicaid/Medicaid HMO ☐ Private Insurance

Verified By: ______________________(staff signature)   Today's Date: ________

NO PATIENT WILL BE DENIED SERVICE DUE TO INABILITY TO PAY

Miami County Public Health – Health History

Date: ______________________

Name____Birthdate__/__/___

Female

General Health	Yes	No	?
1. Are you allergic to any medicines/latex? List:			
2. Are you currently under the care of another physician?			
3. Are you currently taking any medicines, herbals, or vitamins? List			
4. Did you miss any childhood vaccinations? Rubella, Varicella, Hepatitis B or HPV			
5. Have you ever had a blood transfusion?			
6. Do you know your HIV status?			
7. Are you adopted?			

Medical History	Self	Family	N/A	Comment
1. Frequent headaches or migraines?				
2. Seizure or fainting spell?				
3. Thyroid/auto immune disorders?				
4. Heart problems/high cholesterol/blood clots?				
5. Breast problems?				
6. Stomach/bowel/gallbladder problems?				
7. Diabetes/ high blood sugar?				
8. Liver problems/hepatitis/mono?				
9. Kidney/urinary problems?				
10. Blood disorders/anemia/sickle cell?				
11. High blood pressure or stroke issues?				
12. Other				

Sexual History	Yes	No	
1. Sexually active: ___anal ___oral ___vaginal			
2. Sexual partner(s): ___ male ___female ___ both			
3. More than 1 sex partner in the last year/change in partner			
4. Use of condoms with all sex: ___every time ___ sometime			
5. Request testing for sexually transmitted infections			
Have you ever had	Yes	No	Dates treated
1. HPV/Warts			
2. Syphilis			
3. Gonorrhea			
4. Trichomonas			
5. Molluscum			
6. Herpes			
7. Chlamydia			
8. Scabies			
9. Hepatitis A/Hepatitis B/Hepatitis C/Other			

Miami County Public Health – Health History

Date: ____________________

Partner Sexual History	Yes	No	?
Does your partner use injectable drugs?			
Has your partner been diagnosed with HIV or STD?			
Does your partner have sex with ___males ___females ___both			
Does your partner have multiple sex partners?			

Contraceptive History	Never	Now	Past		Never	Now	Past
Pill ____________________				Diaphragm			
Depo Provera Shot				Tubal			
Condom				Vasectomy			
Withdrawal				Rhythm/Natural			
Abstinence				Cervical Cap			
IUD ____________________				Female Condom			
Foam/Sponge/Film				Implanon			

Personal History: Have you ever had........	Yes	No	?	Date
1. An abnormal pap smear?				
2. An abnormal uterus?				
3. Pelvic infection/pain/PID?				
4. Recurrent vaginal infections?				
5. Cervical LEEP/cone procedure?				
6. Any surgeries?				
7. Hospitalization?				

Menstrual and Pregnancy History

1. Age when period started:	1. Number of times pregnant ______
2. Periods are: ___ regular ___ irregular ___painful	2. Live births ______
3. Flow is: ___light ___moderate ___heavy	3. C-sections ______
4. Periods come every ___ days. Bleeding lasts ___ days.	4. Premature births ______
5. When was the 1st day of your last period?	5. Miscarriages _____
6. Was it normal?	6. Abortions _____
7. Date of last Pap: _________ Normal Abnormal	7. Still births _____
8. Treatment:	8. Living children _____
9. Pregnancy complications:	

Reproductive Life Plan	Yes	No
Do you want to be pregnant now?		
Do you want to have children one day?		
If yes: Are you currently using birth control? How many children would you like? _____ At what age would you like to have children? _____ How far apart would you like your children to be? _____		
If no: Are you using a birth control method? What will you do if you become pregnant?		

Miami County Public Health – Health History

Date: ______________________

Emotional Health		
When you feel sad do you bounce back quickly?		
Do you feel sad for more than 2 weeks or more at a time?		
Do you feel nervous, anxious or worried? If yes, how often?		
Is there anyone in your life who is physically abusive?		
Is there anyone in your life who often says hurtful or mean things?		

Personal Goals: ___take a daily vitamin

___start or increase amount of exercise

___quit or reduce the amount I smoke

___ increase or always use a condom

___ use birth control continuously

___quit or reduce the amount of alcohol or drug I use

___ increase/decrease/maintain my weight

Professional Goals:

Education Plan____

Employment Plan ____

FAMILY PLANNING SOCIAL ASSESSMENT

Name:______________________________ Date of Birth: ________ Age: ____ Date: _________

Over 20 Years		
Do you have a good support system?	Yes	No
Do you have transportation?	Yes	No
Do you need help finding housing?	Yes	No
Are you currently living in a shelter?	Yes	No
Do you need help with food?	Yes	No
Do you need help with clothing?	Yes	No
Do you need help with medical insurance?	Yes	No
Are you employed?	Yes	No
Is your income enough to meet the needs of your family?	Yes	No
Do you need financial help with utility bills? Yes/No	Gas Phone	Electric Water
Have you been physically, mentally or sexually abused?	Yes	No
Have you been depressed?	Yes (mild/moderate/extreme)	No
Have you ever thought of hurting yourself?	Yes	No
Any major changes in your family in the past year?	Marriage Birth Separation Death Divorce Move	Serious Illness Job Loss New people living in home
History of drug/alcohol abuse/addiction or recovery	Yes	No

FAMILY PLANNING SOCIAL ASSESSMENT

Name:__________________________________ Date of Birth: _________ Age: ____ Date: __________

Under 20			
Overall, how do you like yourself?	Terrible	OK	Great
How do you get along with your family?	Terrible	OK	Great
How do you get along with friends?	Terrible	OK	Great
How do you get along at school?	Terrible	OK	Great
Current Grade			
Current School			
Grade Average			
How do you get along at home?	Terrible	OK	Great
Name 3 activities you do for fun/exercise	1.	2.	3.
Circle what you like about youself	Personality Honesty Brains	Sense of Humor Looks Athletic ability	Creativity Ability to make friends Other:
Name three people who would stand by you if you needed them. List one adult	1. Relationship to you:	2. Relationship to you:	3. Relationship to you:
List any jobs you are doing now:	1.	2.	3.
Circle what you think of when you think of your future	Job Having kids	Marriage Other:	College
Who do you live with?	Mother Father Other:	Both parents Relative	Friend Partner
<u>Have you ever been...</u> Bullied	Never	In past	Currently
Physically abused	Never	In past	Currently
Forced to have sex	Never	In past	Currently
Used any drugs not given by doctor *Inhaled street drugs *Street drugs by mouth *Used a needle to inject drugs	Never	In past/Amount Drug of choice:	Currently/Amount Drug of choice

Drink alcohol	Never	In past/Amount	Currently/Amount
Do you talk/text when drive?	Never	In past	Currently
Ever tried to hurt yourself	Never	In past	Currently
Do you have questions about your sexual preference	Never	In past	Currently
Smoke Cigarettes Cigarettes Marijuana E-cigarettes Cigars Other __________	Never	In past/Amount	Currently/Amount
Do you have concerns about your diet/weight	Yes	No	

Miami County Public Health – Health History

Date: ____________________

Name____Birthdate__/__/___

Male

General Health	Yes	No	?
1. Are you allergic to any medicines/latex? List:			
2. Are you currently under the care of another physician?			
3. Are you currently taking any medicines, herbals, or vitamins? List:			
4. Did you miss any childhood vaccinations? Rubella, Varicella, Hepatitis B or HPV			
5. Have you ever had a blood transfusion?			
6. Do you know your HIV status?			
7. Are you adopted?			

Medical History	Self	Family	N/A	Comment
1. Frequent headaches or migraines?				
2. Seizure or fainting spell?				
3. Thyroid/auto immune disorders?				
4. Heart problems/high cholesterol/blood clots?				
5. Breast problems?				
6. Stomach/bowel/gallbladder problems?				
7. Diabetes/ high blood sugar?				
8. Liver problems/hepatitis/mono?				
9. Kidney/urinary problems?				
10. Blood disorders/anemia/sickle cell?				
11. High blood pressure or stroke issues?				
12. Genetic disorders?				

Sexual Health History	Yes	No	
1. Sexually active: ____anal ____oral _____ vaginal			
2. Sexual partner(s): __ male __female __ both			
3. More than 1 sex partner in the last year/change in partner			
4. Use of condoms with all sex: ____every time ____ sometime			
5. Request testing for sexually transmitted infections			
Have you ever had	Yes	No	Dates treated
1. HPV/Warts			
2. Syphilis			
3. Gonorrhea			
4. Trichomonas			
5. Molluscum			
6. Herpes			
7. Chlamydia			
8. Scabies			
9. Hepatitis A/Hepatitis B/Hepatitis C/Other			

Date: ____________________

Partner Sexual History	Yes	No	?
Does your partner use injectable drugs?			
Has your partner been diagnosed with HIV or STD?			
Does your partner have sex with ___males ___females ___both			
Does your partner have multiple sex partners?			

Contraceptive History	Never	Now	Past		Never	Now	Past
Count on partners method				Vasectomy			
Condom				Rhythm/Natural			
Withdrawal				Abstinence			

Personal History: Have you ever had……………………………………………………	Yes	No	?	Date
1. Prostate surgery?				
2. Circumcision?				
3. Testicular problems?				
4. Testosterone replacement?				
5. Past surgeries?				
6. Hospitalization?				
7. History of pelvic infection/pain?				
8. History of injury to your scrotum/testicle?				
9. Undescended testicle?				
10. Prostatitis?				

Reproductive Life Plan	Yes	No
Do you want to have children now? How many children do you have? _______ How many children do you care for? _________		
Do you want to have children one day?		
If yes: Are you currently using birth control? How many children would you like? _____ At what age would you like to have children? _____ How far apart would you like your children to be? _____		
If no: Are you using a birth control method? What will you do if your partner became pregnant?		
Emotional Health		
When you feel sad do you bounce back quickly?		
Do you feel sad for more than 2 weeks or more at a time?		
Do you feel nervous, anxious or worried? If yes, how often?		
Is there anyone in your life who is physically abusive?		
Is there anyone in your life who often says hurtful or mean things?		

Date: ______________________

Personal Goals: ___take a daily vitamin ___start or increase amount of exercise

___quit or reduce the amount I smoke ___ increase or always use a condom

___ use birth control continuously ___quit or reduce the amount of alcohol or drug I use

___ increase/decrease/maintain my weight

Professional Goals:

Education Plan____

Employment Plan ____