CLINICARE 621 E. Front, Port Angeles 98362 (360) 452-5000

Request for Confidential Communication of Protected Health Information

_____

Patient Name (Please Print or Type)

Has requested confidential communication of protected health information.

How Should We Contact You:

Mailing Address, Phone Number, Or Other Please Specify.

_____

_____

Who Can We Discuss Your Medical Care With:

Name of Person Other Than Yourself,(If No One Then Please Write Patient Only).

_____

What Can We Discuss?
- ☐ Labs/X-Rays
- ☐ Chart Notes
- ☐ Billing Information
- ☐ Other _____
- ☐ All

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure or Your Protected Health Information. Your protected health information will be used by CliniCare of Port Angeles, Inc. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may and should review the notice prior to signing this consent.

Reservation of Right to Change Privacy Practices. CliniCare of Port Angeles, Inc. reserves the right to modify the privacy practices outlined in this notice.

Signature. I have reviewed this consent form and give my permission to CliniCare of Port Angeles, Inc. to use and disclose my health information in accordance with it.

_____

Name of Patient (Print or Type) **Date**

_____

Signature of Patient or Representative **Relationship to Patient**

Today's Date _____

HISTORY

PLEASE PRINT — THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD — PLEASE PRINT

NAME

_____
LAST FIRST MIDDLE INITIAL

ADDRESS _____

_____

PHONE _____

DRUG ALLERGY _____

_____

TYPE OF WORK _____

REFERRED TO OUR CLINIC BY: _____

PAST HISTORY (GIVE NAMES AND DATES)

PREVIOUS SURGERY	
PREVIOUS HOSPITALIZATIONS MAJOR-ILLNESS OR INJURY	

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS: NUMBER: _____			
SISTERS: NUMBER: _____			
CHILDREN: NUMBER: _____			

NUMBER LIVING IN YOUR HOUSEHOLD _____

CHECK IF ANY RELATIVES HAVE HAD

- DIABETES ☐
- HEART DISEASE ☐
- HEART ATTACK ☐
- HIGH BLOOD PRESSURE ☐
- STROKE ☐
- CANCER ☐
- TUBERCULOSIS ☐
- ULCERS ☐
- ARTHRITIS ☐
- OBESITY (OVER WEIGHT) ☐
- SUICIDE ☐
- GLAUCOMA ☐
- THYROID TROUBLE ☐
- ASTHMA / ALLERGIES ☐

_____

SMOKING:
PACKS PER DAY _____
NO. OF YEARS _____
YEARS STOPPED _____
PIPE ____ CIGAR ____ CHEW ____

ALCOHOL:
NEVER ____ OCCASIONAL ____
MODERATE ____ HEAVY ____
ALCOHOL PROBLEM:
YES ____ NO ____

COFFEE:
CUPS PER DAY _____

ASPIRIN:
TABS PER DAY _____

SUBSTANCE ABUSE:
DRUG _____
LAST USE _____

WEIGHT CHANGE LAST YEAR:
GAINED _____ LBS LOST _____ LBS

HEIGHT
_____

LIST CURRENT DRUGS USED

SLEEPING PILL		TRANQUILIZER		ANTI-DEPRESSANT	
DIET PILL		DIABETIC PILL		ESTROGEN HORMONE	
BIRTH CONTROL PILL		INSULIN		CORTISONE	
THYROID		HEART PILL		DIGITALIS	
NITROGLYCERIN		WATER PILL (OR DIURETIC)		BLOOD PRESSURE PILL	
"HARD DRUGS"		LAXATIVE		ANTACIDS	
DECONGESTANT		VITAMINS		IRON	
ANTIBIOTICS		ASTHMA PILLS		OTHER (SPECIFY)	

OVER

HISTORY

SYSTEM REVIEW: CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDING TO AN UNUSUAL OR SIGNIFICANT DEGREE

- HEADACHE ☐
- FAINTING ☐
- DIZZINESS ☐
- SEIZURE ☐
- EAR TROUBLE ☐
- SINUS TROUBLE ☐
- STUFFY NOSE ☐
- NOSE BLEEDS ☐
- ALLERGY ☐
- PLEURISY ☐
- NIGHT SWEATS ☐
- COLITIS ☐
- LIVER DISEASE ☐
- TUMOR OR SWELLING ☐
- BACK PAIN ☐
- VARICOSE VEINS ☐
- LOW BLOOD SUGAR ☐
- TROUBLE SLEEPING ☐
- SUGAR IN URINE ☐
- FRIGIDITY ☐
- DIFFICULTY URINATING ☐
- LOSS OF APPETITE ☐
- INDIGESTION ☐
- HEART BURN ☐
- NERVOUS STOMACH ☐
- ULCERS ☐
- VOMITING BLOOD ☐
- PASSING BLOOD ☐
- ABDOMINAL PAIN ☐
- HOARSENESS ☐
- PNEUMONIA ☐
- CHEST PAIN ☐
- DIARRHEA ☐
- ANEMIA ☐
- HEART TROUBLE ☐
- BURSITIS ☐
- PHLEBITIS ☐
- DIABETES ☐
- KIDNEY TROUBLE ☐
- BLOOD IN URINE ☐
- TROUBLE SWALLOWING ☐
- YELLOW JAUNDICE (HEPATITIS) ☐
- HEART MURMUR ☐
- RHEUMATIC FEVER ☐
- PALPITATION ☐
- IRREGULAR HEART BEAT ☐
- TIRE EASILY ☐
- ANGINA ☐
- ENLARGED HEART ☐
- HIGH BLOOD PRESSURE ☐
- COUGH ☐
- TUBERCULOSIS ☐
- COUGHED UP BLOOD ☐
- CONSTIPATION ☐
- BLOOD DISORDER ☐
- ANKLE SWELLING ☐
- MUSCLE CRAMPS ☐
- ABNORMAL X-RAY ☐
- DEPRESSED ☐
- URINE INFECTION ☐
- INFERTILITY ☐
- CHANGE IN BOWEL HABITS ☐
- ABNORMAL ELECTRO-CARDIOGRAM (EKG) ☐
- HYPOGLCEMIA ☐
- THYROID TROUBLE ☐
- GOITER ☐
- HOT FLASHES ☐
- FLUID RETENTION ☐
- WEAKNESS ☐
- NERVOUS ☐
- IRRITABLE ☐
- WHEEZING ☐
- SHORTNESS OF BREATH ☐
- ASTHMA ☐
- HEMORRHOIDS ☐
- SKIN TROUBLE ☐
- ARTHRITIS ☐
- NUMBNESS ☐
- HIGH BLOOD SUGAR ☐
- TIRED ☐
- PROSTATE TROUBLE ☐
- IMPOTENCE ☐
- GALL BLADDER TROUBLE ☐
- OTHER ☐

ACTIVITY: (CHECK ONE OR MORE BOXES)

I SEDENTARY LIFE WITH LITTLE EXERCISE ☐

II MILD EXERCISE WITH JOB, HOUSE OR RECREATION (CLIMB STAIRS, WALK OVER 3 BLOCKS, GOLF, BOWL, ETC.) ☐

III OCCASIONAL VIGOROUS ACTIVITY WITH WORK OR RECREATION ☐

IV REGULAR VIGOROUS EXERCISE PROGRAM OR HARD WORK ☐

FOR WOMEN

DATE LAST MENSTRUATED? _____

PERIOD EVERY _____ DAYS

ANY MENSTRUAL PROBLEMS? YES _____ NO _____

HEAVY PERIODS _____ IRREGULAR PERIODS _____

INFREQUENT PERIODS _____ PAINFUL PERIODS _____

SPOTTING _____ DISCHARGE _____

NUMBER OF PREGNANCIES _____

NUMBER OF MISCARRIAGES _____

DATE OF LAST PAP SMEAR _____

CHECK IF YOU HAVE HAD:

D & C _____ HYSTERECTOMY _____ TOXEMIA _____ CESAREAN SEC. _____

DIFFICULTY WITH PREGNANCY _____ WITH LABOR _____ WITH DELIVERY _____

MALE / FEMALE

BIRTH CONTROL METHOD (IF ANY) _____