GILLETTE REPRODUCTIVE HEALTH
History Form

Client Name	Age	Date of Birth	Today's Date

LIST all ALLERGIES to food and/or medications?

Who is your regular healthcare provider? _____

Do you have any of these immunizations (shots) completed?

☐ MMR ☐ Tetanus Booster ☐ Hepatitis B series ☐ Hepatitis A ☐ Meningitis ☐ Varicella (Shingles) ☐HPV (Gardasil)	**COMMENTS**

	Now	Past	Never	
Please list prescription drugs or over the counter meds including vitamins etc., you take regularly.				
Anemia (iron-poor blood)?				
Any breathing or lung problems?				
Blood clots? Heart disease, stroke or high blood pressure?				
Chronic headaches diagnosed migraines?				
Depression or other mental health concerns?				
Diabetes? Other blood sugar problems?				
Liver or gallbladder disease?				
Seizures or diagnosed with epilepsy?				
Thyroid problems or take thyroid medication?				
Have you or your partner(s) used any IV drugs?				
Have you or your partner(s) had a blood transfusion?				
Have you had an operation or been hospitalized?				
Have you ever been forced to have sex?				
Have you been in a relationship with a person who verbally threatens or physically hurts you (hit, slap, kick or otherwise)?				

	Now	Past	Never	
Do you check your breasts for lumps every month? Any concerns today?				
Do you check your testicles for lumps every month? Any concerns today?				
Are you having sex with someone?				
Do you have pain, bleeding, or any other difficulty with sex?				
Have you ever had a sexually transmitted disease?				
Do you have a discharge, rash, sores, bumps, itching, or pain?				
How old were you when you first had sex?				
Do you use condoms regularly?				
Do your partners have other partners besides you?				
How many sexual partners in the past three months?				
How long have you been with your current partner?				
Do you use tobacco products (cigarettes, vape or chew)?				
Do you use street drugs (marijuana, cocaine, meth)?				
Do you drink alcohol?				
Any concerns about diet? Do you want to lose/gain weight?				
Do you see your dentist regularly?				
Are you and your partner currently trying to have a child?				

Family History	YES	NO	Unknown	
Diabetes?				
Blood clot or other bleeding disorder?				
High blood pressure? Stroke? Heart attack or heart disease?				
Any cancer? What type?				
Birth defects? Genetic disorders?				
Are your parents and siblings generally in good health?				

CONTRACEPTIVE Prevention and Safety

What methods of birth control have you used in the past? ☐ None ☐ Plan B ☐ Depo Provera ☐ Pills

☐ Diaphragm ☐ Patch ☐ Pulling out ☐ Rhythm ☐ Fertility awareness ☐ Condoms ☐ Sponge

☐ Vaginal Ring ☐ Spermicidal (foam) ☐ IUD ☐ Sterilization _____

☐

What method are you using now?	
What method would you like to use?	

How old were you when your first period started?		
How often do you get your period?		
How many days does your period last?		
Do you have bleeding at other times besides normal period?		
Do you have pain/cramps or other problems with periods?		
What was the first day of your last period?		
When was your last Pap?		
Have you ever had an abnormal Pap?		

List your pregnancies: **Full Term _____ _____** **Premature or low birth weight _____** **Abortion /Miscarriage/Still Birth _____** **Living children_____ _____** **C-section _____** **Vaginal _____**			

The information I have provided on this form is correct and complete to the best of my knowledge.

Client Signature: _____

Reviewed by: _____ Date: _____

Gillette Reproductive Health
Signature Sheet

Name: _____ DOB:_____

_____ **HIPAA Notice & Patient Bill of Rights & Responsibilities:**

I have reviewed the posted Gillette Reproductive (GRH) Health HIPAA Notice of Privacy Practices and Patient Bill of Rights and Responsibilities statements. A copy is available upon request.

_____ **Insurance Assignment of Benefits Authorization**

I authorize Gillette Reproductive Health to disclose medical or other information required to process claims. I understand that third party payers will be billed full price for services received. If charges are denied by insurance, a balance due adjustment will be made by GRH according to the appropriate individual fee scale. I understand that payments from third—party payers will be made directly to Gillette Reproductive Health. All balances will be my financial responsibility.

_____ **Statement of Personal & Financial Inventory**

I certify that I have provided true and accurate personal and financial information to be used by Gillette Reproductive Health to determine my eligibility for grants and the GRH sliding fee scale.

_____ **Late Fee Notification**

In order to maintain low costs in all service areas, payment is due on the day of service. There will be a service fee of $10.00 per month added to all accounts carrying a late balance until paid in full. GRH reserves the option to send overdue balances to collections at any time.

_____ **Consent for Services**

I am here of my own free will to receive healthcare services from Gillette Reproductive Health staff . Services for MINORS: It is a policy directive of federal funding that all clients under the age of 18 be **encouraged to involve parents or guardians** concerning reproductive health care. Without your permission we will not discuss your services nor will we inform your parents or guardians of your visits to this clinic.

My signature acknowledges receipt, review, and agreement with all of the above information and directives.

Signature: _____ Date: _____

Personal & Financial Inventory

Name: ______________________________ Email: _____________________________________

BEST Phone: _______________________ Alternate phone: ________________________________

DOB: _________________ Age: _____ Gender: ________ Years of school completed: ________

I am: _____ single _____ married _____divorced _____ Living with Partner _____ Other

Mailing Address: ____

City/State/Zip: ____

EMERGENCY CONTACT: _________________________________ Relationship to you: __________

Address: ____ Phone: _____________________

Name and age of all members of your household:

Name: ________________________ Age: _____ Name: ________________________ Age:______

Name: ________________________ Age: _____ Name: ________________________ Age:______

Name: ________________________ Age: _____ Name: ________________________ Age:______

Name: ________________________ Age: _____ Name: ________________________ Age:______

Gross monthly income for each household member including you:

You	**Name:**	**Name:**	**Name:**	**COPIES needed**
$	$	$	$	Current Employment Check Stub or Tax Return
$	$	$	$	Social Security Award Letter
$	$	$	$	Disability Award Letter
$	$	$	$	Public Assistance Check Stub
$	$	$	$	SSI Medicaid Coupon
$	$	$	$	Child Support Divorce Decree or Bank Statement
$	$	$	$	Food Stamps Card
$	$	$	$	Unemployment Check Stub

I am aware that my chart may be audited or reviewed for financial or regulatory purposes

Patient Signature: ______________________________ DATE: ______________

* * * * * * ** *

FOR OFFICE USE ONLY:

Sliding Fee Scale: 1 2 3 4 5

CSBG Eligible: YES NO CCPH: YES NO