

Woman to Woman Gynecology

A-All Women Care

7908 W. Sahara Ave. Las Vegas, NV 89117

(702) 531-5400

Clarification of Charges for Pregnancy Termination Services

Pre Procedure Charges

- \$200.00 Consultation
- \$240.00 Ultrasound
- \$95.00 Rh Factor Testing
- \$60.00 HCG Testing
- \$60.00 Syphilis Testing

Medical Termination

- \$650.00 Uncomplicated Medical Termination
- \$60.00 Price for follow up visit-pelvic ultrasound
- \$260.00 Office DE for Failed Medical Termination
- \$700.00 Office Emergency D+E for Failed Medical Termination

Surgical Termination Services and Price Changes

- \$650.00 ≤ 12 weeks
- \$700.00 12^{1/7}, 12^{2/7}, 12^{3/7} weeks
- \$740.00 12^{4/7}, 12^{5/7}, 12^{6/7} weeks
- \$750.00 13 weeks
- \$800.00 13^{1/7}, 13^{2/7}, 13^{3/7} weeks
- \$840.00 13^{4/7}, 13^{5/7}, 13^{6/7} weeks
- \$850.00 14 weeks
- \$900.00 14^{1/7}, 14^{2/7}, 14^{3/7} weeks
- \$950.00 14^{4/7}, 14^{5/7}, 14^{6/7} weeks

- \$115.00 Placenta Previa
- \$115.00 Prior C-Section scars
- \$115.00 Multiple fibroids, Uterine Structural Anomaly
- \$115.00 Twin Gestation
- \$115.00 Psychosocial Issues - addiction, family discord, Interaction with social services.
- \$1700.00 Surgical Treatment for Blighted Ovum

Clarification of Charges for Pregnancy of Unknown Location

- | | |
|---|---|
| \$200.00 Initial Consultation | |
| \$115.00 Follow-up Consultation with the doctor | <u>Each time</u> that the patient is seen |
| \$240.00 Pelvic ultrasound | <u>Each time</u> that it is performed |
| \$60.00 Pregnancy blood test | <u>Each time</u> that it is performed |
| \$95.00 RH blood testing | \$115.00 CMP and CBC blood testing |

Treatment of Ectopic Pregnancy

- \$1700.00 Surgical Fees for treatment of Ectopic Pregnancy-Doctor's Surgical Fees (Hospital fees are extra)
- \$1700.00 In - office Medical treatment of Ectopic Pregnancy - Medication (Methotrexate), blood testing, visits, ultrasounds.
Should surgery be required- when ectopic treatment fails-then both surgical and medical fees will apply.

Hospital Treatments for Pregnancy Termination Complications

Infections, abnormal clotting, prior C/S scars, placental abnormalities causing bleeding that require hospital treatments

- \$320.00 Emergency room consultation and treatment plan
- \$2520.00 Emergency or scheduled surgery such as Total Abdominal Hysterectomy due to sepsis, bleeding or other conditions
- \$250.00 Daily hospital charges for care of patient with complications from pregnancy termination
- \$1100.00 Dilation and Evacuation for Retained Products of Conception

Clarification of Charges for Additional Services and Treatments

- | | |
|--|--|
| \$140.00 Mini Rhogam | \$220.00 Full Dose Rhogam ≥ 12wk |
| \$170.00 IV Hydration – Each Bag of Hydration | \$55.00 Nausea Injection: Zofran or Metochlopramide |
| \$20.00 Oral Zofran | \$20.00 Oral Antacid Medication |
| \$60.00 Oral Antibiotics | \$55.00 Toradol Injection (for pain relief) |
| \$60.00 Additional Misoprostol for bleeding prevention | \$140.00 Intramuscular Methergine for heavy bleeding |
| \$50.00 Flu Shot | \$55.00 No show fee |

If you decide to NOT move forward with completing the pregnancy termination after receiving a consult and ultrasound you are still responsible for payment of the services you have received. The charges of: \$200 for the consult and \$240 for the ultrasound. Total charges \$440.

Signature: _____

Date: _____

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PATIENT INFORMATION *Información Del Paciente*

Today's Date: _____
Fecha

Name: (Last, First): _____
Nombre

Date of Birth: _____ / _____ / _____ Age: _____ Social Security# _____
Fecha de Nacimiento Mes Dia Año *Edad* *Seguro Social*

Address: _____ Apt#: _____
Dirección

City: _____ State: _____ Zip Code: _____
Ciudad *Estado* *Código Postal*

Home Phone#: _____ Cell Phone#: _____
Teléfono de casa *Teléfono de celular*

Email Address: _____
Correo Electrónico

Employer: _____ Occupation: _____
Empleador *Ocupación*

Work Phone#: _____
Teléfono de trabajo

Marital Status: (Circle one): Single Married Divorced Separated Widowed
Estado Civil *Soltera* *Casada* *Divorciada* *Separada* *Viuda*

Race: White Asian Pacific Islander Black or African American
Native American Indian Middle Eastern/North American Other: _____
(Please Specify)

Ethnicity: Hispanic or Latino Not Hispanic or Latino Specify: _____
Especifique

EMERGENCY CONTACT INFORMATION *En Caso de Emergencia Notifique*

Emergency Contact: _____
Contacto de Emergencia

Phone: _____ Relationship: _____
Teléfono *Relación*

Nearest Friend or Relative Not living with you: _____
La Persona o Amistad que no Vive con Usted

Phone: _____ Relationship: _____
Teléfono *Relación*

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PRIMARY INSURANCE INFORMATION

Información de Asegurancia Pimaria

Primary Insurance: _____ Policy#: _____
Seguro Primario *Number de Póliza*

Claims Address: _____ City: _____
Dirección de Reclamar *Cuidad*

State: _____ Zip Code: _____ Phone#: _____
Estado *Código Postal* *Teléfono*

Policy Holder: _____ Insured D.O.B ____/____/____
Titular de la Póliza *Fecha de Nacimiento*

Relationship to Patient: _____ Social Security of Insured: _____
Relación *Seguro Social del Asegurado*

Employer: _____ Occupation: _____
Empleador *Ocupación*

SECONDARY INSURANCE INFORMATION

Información de Asegurancia Secundaria

Secondary Insurance: _____ Policy#: _____
Seguro Secundario *Number de Póliza*

Claims Address: _____ City: _____
Dirección de Reclamar *Cuidad*

State: _____ Zip Code: _____ Phone#: _____
Estado *Código Postal* *Teléfono*

Policy Holder _____ Insured D.O.B ____/____/____
Titular de la Póliza *Fecha de Nacimiento*

Relationship to Patient: _____ Social Security of Insured: _____
Relación *Seguro Social del Asegurado*

Employer: _____ Occupation: _____
Empleador *Ocupación*

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2024 Office Policies

Insurance Policies and Payments:

Our goal is to provide you with the best possible care. We want to be efficient, effective, and diligent in our interactions with you. We cannot practice good medicine or business without timely payments.

As a result, **all payments are due at the time of service.**

Our office is NOT contracted with most insurance and does not accept insurance fee schedules.

Our fee schedules are based on 120-150% of Medicare rates.

_____ ***Patient Initials***

Labs and Testing:

We are not contracted with Insurances for Office Visits or Procedures done in office. We are able to use insurances toward labs or testing done in office. If we send out your specimen (s) to a lab for processing though your insurance we are not responsible for any bills you receive from the lab.

If you do not have insurance, or would prefer not to use your insurance, you are responsible for paying the lab fee in our office. You are also responsible for calling the lab within 24 hours for Pap smear collections for the discounted price.

We are not responsible for any bills you have received from the lab.

_____ ***Patient Initials***

Communications with Patient:

By supplying my telephone number, I understand that I may receive calls or text message reminders from our office. Phone calls may be made in regard to office visits, test results, or medications. We will not discuss any information over the phone until we have confirmed we are speaking directly to you. If you are unable to answer the phone, we will leave a general message that does not disclose any Personal Health Information.

Text Messages are for appointment reminders. Receiving them is completely optional. You may opt out of them at any time.

_____ ***Patient Initials***

Balances on Accounts:

Your balance will be due at your follow up visit, unless, there are special circumstances, such as, payment arrangements scheduled in collaboration with the office manager.

_____ ***Patient Initials***

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Acknowledgement of the Notice of Privacy Practices

I hereby acknowledge that I have reviewed the "Notice of Privacy Practices" from Woman to Woman Gynecology. I understand that the "Notice of Privacy Practices" sets forth my rights relating to the use and disclosure of my personal health information and explains how Woman to Woman Gynecology use and disclose my personal health information, both with and without my authorization. I further understand that I may contact Woman to Woman Gynecology if I have any questions regarding the contents of this notice, or to file a complaint.

_____ ***Patient Initials***

No "Insurance Assignment" For Abortion Services

Any and all abortion services provided by Dr. Contomitros in office, or at the Hospital, are paid for by Cash, Debit, or Credit Card only.

Woman to Woman Gynecology does NOT bill insurances for any abortion services.

Woman to Woman Gynecology does NOT accept insurance assignments for abortion services.

_____ ***Patient Initials***

Missed Appointment Policy

Should you cancel your appointment in less than 24 hours, or not show up for your appointment without giving us a courtesy call, there will be a **\$55.00** charge applied to your account for the missed appointment date. This amount is payable prior to the provision of any other future services.

We contact via SMS/Email/Phone call in advance with a reminder of their visit time.

Attestation by patient:

I am aware of the policies and I understand that I will be charged for late cancellations of appointment or for not showing up for my scheduled services.

_____ ***Patient Initials***

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Credit Card Payments

A 3.99% fee will be applied when services are paid by credit and debit. There are no fees when paying with cash.

_____ *Patient Initials*

Cardholder Policy:

It is our policy that the cardholder be present at the time of the appointment. Any charges that are refunded if the cardholder is not present will become the patient's responsibility.

_____ *Patient Initials*

Prescription refills:

No prescriptions will be refilled unless the account is paid in full or is up-to-date with the payment schedules. All prescriptions must first be approved by Dr. Anna Contomitros.

We are unable to fill prescriptions for Birth Control over 3 months unless an Annual Exam has been completed.

_____ *Patient Initials*

Collaboration between Patients and Office Providers:

We desire to help you at all times. Getting better, feeling well and being satisfied requires our mutual collaboration. So, we absolutely need your help in taking care of you! Failure to follow up with our instructions to do testing, to get your mammograms, biopsies, consultations, failure to show up for your appointments, repeatedly canceling your appointment, all will be considered as an indication that our collaboration in your best interest is not working. We will dismiss patients from our practice that are not civil to our staff and who are inconsistent with their health commitments or their payments to our practice.

We have zero tolerance for obscenities or any form of verbal or physical violence. We do not allow weapons in our office. We do not allow unauthorized photos of our staff and doctor.

Name: _____ **Date:** _____

Signature: _____ **Date:** _____

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Release of Records:

If anyone were to call on your behalf, we are unable to disclose any information about you, your office visit, or your test results unless they are listed below. You do have the option of marking "No one".

I, _____, give Anna Contomitros, M.D. of A-All Women Care and Woman to Woman Gynecology, the authorization to release and discuss any information about myself and the following people.

<input type="radio"/> No one		
<input type="radio"/> _____	_____	_____
	Name	Relationship
<input type="radio"/> _____	_____	_____
	Name	Relationship
<input type="radio"/> _____	_____	_____
	Name	Relationship
<input type="radio"/> _____	_____	_____
	Name	Relationship

I understand that is my full responsibility to notify the office of any changes.

Signature: _____ **Date:** _____

Date: _____

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Last name: _____ First name: _____ Date of birth: _____

Last Menstrual Period: _____ Was it normal? Yes No If No, please describe: _____

Are you menopausal or postmenopausal? Yes No I experience no more periods due to: _____

Why are you here today?

- Routine Annual Visit with **NO** problems
- Are you having any gynecologic problems you want to discuss with the doctor? _____

Are you **CURRENTLY** experiencing any of the following (please circle those that apply): **Select if none**

Neurological: dizziness, numbness in arms or legs, trouble walking, other: _____

Eyes: double vision, spots before eyes, vision changes, other: _____

ENT/Mouth: ear aches, ringing in ears, sinus problems, sore throat, mouth sores, other: _____

Cardiovascular: swelling of the legs, chest pain, blood clots in legs or lungs, other: _____

Respiratory: spitting up blood, shortness of breath, coughing, other: _____

Gastrointestinal: diarrhea, constipation, nausea or vomiting, bowel trouble, blood in stool, black stools, incontinence of stool, other: _____

Genitourinary: blood in urine, painful urination, frequent urination, painful intercourse, vaginal: discharge, odor, or itching, urine incontinence, other: _____

Musculoskeletal: muscle pain, joint pain, muscle weakness, joint weakness, other: _____

Constitutional: weight loss, weight gain, fatigue, fever, changes in appetite, difficulty sleeping, other: _____

Endocrine: hot flashes, abnormal thirst, other: _____

Hematologic/Lymphatic: enlarged lymph nodes, continuous bleeding, bruising easily, other: _____

Psychiatric: thoughts of suicide, frequent crying, depression, anxiety, other: _____

MEDICATION INFORMATION

Please list the **PHARMACY** you would like us to use if you needed a prescription. **Name and cross streets or phone number.**

Do you have any **ALLERGIES** to medications, latex, or iodine? If so, please list them and your reactions:

List any **MEDICATIONS** (prescription and over the counter), **Vitamins, or supplements** you are taking and the dosage.

Name	Dose
_____	_____
_____	_____
_____	_____

Do you smoke tobacco (select applicable choice)?

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

Date Quit: _____

Do you use any smokeless tobacco, if so how often? _____

Do you drink alcohol ever, if so how often and how many drinks average? _____

Do you currently use or have used in the past any street drugs? If so please list names and last time used? _____

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PREVENTIVE CARE

When was your last?	Date	Was it normal?			If No, explain:
Pap smear	_____	Yes	No	N/A	_____
Mammogram	_____	Yes	No	N/A	_____
DEXA Scan	_____	Yes	No	N/A	_____
Colonoscopy	_____	Yes	No	N/A	_____

Have you had the following (mark all that apply and dates): **Select if none**

- Gardasil vaccine (ages 9-26 for the prevention of cervical cancer and genital warts: _____)
- Flu vaccine: _____
- Pneumococcal vaccine _____

PREGNANCY HISTORY **Select if none**

How many times have you been pregnant? _____ How many ectopic/tubal pregnancies? _____

How many children do you have? _____ How many miscarriages? _____

How many vaginal deliveries? _____ How many abortions? _____

How many C-Section deliveries? _____ How many deceased? _____

Describe any problems you had during the prior pregnancies, include details: **Select if none**

- Rh Negative
- Severe bleeding requiring transfusions
- Diabetes
- High Blood Pressure
- Clots in the lungs or legs (DVT)
- Infections
- Congenital anomalies
- Any other problems or difficulties: _____

CONTRACEPTIVE HISTORY **Select if none**

Are you using any contraception **currently**, if so which one? _____

Have you used any of these below?

- Birth control pills (include names)
- Nuvaring
- Ortho-Evra Patch
- IUD Mirena/Skyla/Paragard
- Nexplanon
- Depo-Provera shot
- Diaphragm
- Tubal Ligation

Describe any **problems** you had while taking them: _____

Please mark if **you currently have or previously had** any of the following while taking hormonal contraception: **Select if none**

- Smoker
- Migraine Headaches
- High Blood Pressure
- Breast Cancer
- Liver Problems
- Varicose Veins
- Gallbladder Problems
- Blood clots of the legs or lungs
- Family member with blood clots of the legs or lungs

SEXUAL HEALTH HISTORY **Select if none**

- Difficulties with intercourse
- Pain with intercourse
- Dryness with intercourse
- Inability to have an orgasm
- Decreased desire for intercourse
- Bleeding with intercourse

BREAST HISTORY **Select if none**

- Fibrocystic changes
- Blocked Milk Ducts
- Cysts
- Fibroadenomas
- Intraductal Papillomas
- Mastitis
- Nipple discharge
- Biopsy
- Breast cancer

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GYNECOLOGIC HISTORY (Please mark those that apply to you, including dates where possible) Select if none

- Pelvic Infections: Chlamydia, gonorrhea, mycoplasma, ureaplasma
- Vaginal Infections: yeast, bacterial vaginosis, beta strep
- Abnormal Pap smear
- HPV Infection
- Genital Warts
- Dysplasia
- Molluscum contagiosum
- Trichomonads
- Heavy or Painful periods
- Pelvic scarring (adhesions)
- Uterine fibroids
- Ovarian cysts
- Inflamed blocked fallopian tubes (Salpingitis)
- Uterine Cervical Ovarian Cancer
- Ovarian Cancer
- Fallopian Tube Cancer
- Cervical Cancer
- Urgency (the sensation to urinate all the time)
- Endometriosis
- Frequency: the need to urinate frequently
- Loss of urine with sneezing, coughing, or laughing
- Needing to wear diapers or pads to prevent being wet
- Uterine or vaginal anomalies: double uterus, double vagina, double cervix
- Nocturia: waking up at night to use the bathroom more than once per night

Prolapse of pelvic organs: Select if none

- Uterine prolapse
- Cystocele (prolapse of the bladder)
- Rectocele (prolapse of the rectum)
- Enterocele (prolapse of the bowel)

HORMONAL HEALTH HISTORY Select if none

When was menopause for you (year and age)? _____

Hormonal Changes (select those that apply to you):

- Hot flashes
- Night and day sweats
- Weight gain
- Poor Bone Health
 - Loss of height
 - Osteopenia
- Memory loss
- Dry skin
- Mood changes
- Osteoporosis
- Fractures
- Lack of sexual desire
- Vaginal dryness
- Vitamin D status

FAMILY HISTORY Select if none

Has anyone in your family ever had the following, please list relation and their age of diagnosis if known.

- Breast Cancer _____
- Colon Cancer _____
- Ovarian Cancer _____
- Endometrial Cancer _____
- Cervical Cancer _____
- Diabetes _____
- Other (please describe): _____
- High blood pressure _____
- Stroke _____
- Heart disease _____
- Thyroid disorder _____
- Addiction _____
- Seizures/Epilepsy _____

SOCIAL HISTORY

Please mark appropriate sexual orientation:

Heterosexual Bisexual Lesbian Decline to answer

Please select current relationship status:

Single Married Long term monogamous relationship
Separated Divorced Widowed

Please select current gender identity:

Female Non-Binary/Non-Conforming Male Other: _____

Please list current occupation: _____

Highest education level (select one):

Some high school: _____ yrs.	Some College: _____ yrs.	Master's Degree
Graduated High School	Associates Degree	PhD
GED	Bachelor's Degree	Technical/Trade school

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GENERAL HEALTH HISTORY Do you have any of the following?

Neurological:

- None
- Seizures/Epilepsy
- Numbness
- Other: _____
- Migraine headaches

Eyes:

- None
- Macular degeneration
- Cataracts
- Other: _____
- Glaucoma

ENT/Mouth:

- None
- Other: _____

Cardiovascular:

- None
- Stroke
- Heart disease
- Varicosities
- Blood clots of the legs or lungs
(Deep Vein Thrombosis)
- Circulatory problems
(describe): _____
- Other: _____
- High blood pressure

Respiratory:

- None
- Chronic Lung Disease
- Tuberculosis
- Seasonal allergies
- Other: _____
- Asthma

Genitourinary:

- None
- Urine retention
- Urine Incontinence
- Kidney stones
- Bladder cancer
- Kidney cancer
- Other: _____
- Kidney disease

Psychiatric: Select if none

- Addiction (please provide information): _____

- Mental Illness (please provide information): _____

Gastrointestinal:

- None
- Crohn's disease
- Gastritis
- Esophagitis
- Bowel incontinence
- Ulcers
- GERD
- Colonic polyps
- Stomach cancer
- Bowel Cancer
- H. Pylori infection
- Hepatitis Infection
- Other: _____
- Ulcerative colitis

Musculoskeletal:

- None
- Hernia (location): _____
- Osteoporosis
- Osteopenia
- Arthritis
- Other: _____
- Fractures

Endocrine:

- None
- Thyroid disorder
- Thyroid cancer
- Multiple Endocrine Neoplasia
- Other: _____
- Diabetes

Hematologic/Lymphatic/Autoimmune:

- None
- Leukemia
- Hodgkin's Lymphoma
- Sjogren's
- Other: _____
- Lupus

Integumentary (Skin):

- None
- Melanoma
- Psoriasis
- Other: _____
- Basal cell carcinoma

- None
- Depression
- Anxiety

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SURGICAL HISTORY Please list all surgeries and the date of the procedure under appropriate body system.

Neurological (The brain, spinal cord, or nervous system)

- None
- Other: _____

Eye surgery

- None
- Cataract removal
- Other: _____

ENT/Mouth:

- None
- Tonsillectomy
- Adenoidectomy
- Thyroidectomy
- Parathyroidectomy
- Other: _____

Cardiovascular:

- None
- Angioplasty
- Cardiac bypass surgery
- Stent placement
- Radiofrequency ablation
(For abnormal heart rhythm)
- Heart transplant
- Other: _____

Respiratory:

- None
- Thoracotomy
- Lobectomy
- Lung transplant
- Other: _____

Musculoskeletal:

- None
- Knee replacement
- Hip replacement
- Other: _____

Breast:

- None
- Mastectomy for cancer
- Lumpectomy
- Breast implants
- Other: _____

Gastrointestinal:

- None
- Cholecystectomy (Removal of gallbladder)
- Appendectomy (Removal of appendix)
- Pancreatectomy (Pancreatic surgery)
- Colectomy (Removal of part of colon)
- Hemorrhoidectomy
- Hernia repair
- Other: _____

Genitourinary:

- None
- Hysterectomy (Removal of uterus and cervix)
- Salpingo -Oophorectomy (Removal of ovaries/tubes)
- Cystectomy (Removal of ovarian cyst)
- Myomectomy (Removal of fibroids)
- Laparoscopy (Looking inside the abdomen)
- Tubal Ligation (Tie tubes for contraception)
- Pelvic prolapse (Repair of vaginal hernia)
- Mesh for prolapse
- Cystocele repair (Repair of bladder prolapse)
- Rectocele repair (Repair of rectum prolapse in vagina)
- Enterocele repair
- Nephrectomy
- Lithotripsy
- Cystoscopy
- Other: _____

Hematologic/Lymphatic:

- None
- Lymph node resection
- Other: _____

Endocrine:

- None
- Thyroid surgery
- Other: _____

I have answered all the questions truthfully and I have not withheld any information that might affect my medical care.

Patient Name (Please print): _____

Signature of Patient: _____ Date: _____

Physician's Signature: _____ Date: _____

Sexual Health Clinic Client Health History

Please complete this form as much as possible. All information is confidential

Today's Reason for Visit	
<input type="checkbox"/> No symptoms or problems, I just want testing <input type="checkbox"/> Call from Health Dept. <input type="checkbox"/> I have an appointment <input type="checkbox"/> Partner/Doctor told me to come <input type="checkbox"/> Other (please explain):	<input type="checkbox"/> I have symptoms (check all that apply) <input type="checkbox"/> Abnormal discharge <input type="checkbox"/> Odor <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Burning when I pee <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Sores/bumps in genital area <input type="checkbox"/> Swelling/pain in testicle(s) <input type="checkbox"/> Other (please explain):

PATIENT MEDICAL HISTORY		FAMILY HISTORY	If yes, list person
Have you ever been told by a doctor, nurse, or other health professional that you have:		(parents, sibling)?	
Diabetes? Check all that apply	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Prediabetes <input type="checkbox"/> Borderline Diabetes			
<input type="checkbox"/> Heart Attack <input type="checkbox"/> Angina <input type="checkbox"/> Coronary Health Disease <input type="checkbox"/> Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Tract Infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> Lung Problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Chronic Health Problems:			
Hospitalizations:			
Prior sexually transmitted diseases (check all that apply): <input type="checkbox"/> Select if none <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis			
<input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Herpes <input type="checkbox"/> Genital Warts <input type="checkbox"/> Chlamydia <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Hepatitis			
Diagnosed with HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No IF yes, the date diagnosed: _____			
Diagnosed with AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF yes, the date diagnosed: _____			
Do you see a doctor/provider? <input type="checkbox"/> Never <input type="checkbox"/> Within past 6 months <input type="checkbox"/> More than year			
Date last seen by provider: _____ Where: _____ Reason: _____			
Did you receive a flu vaccine this year: <input type="checkbox"/> Yes <input type="checkbox"/> No Other vaccines?			
Allergies (drugs/ others)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:			
List all HIV medications ever taken:			
List all other medications taken in the past 2 weeks:			
FEMALES ONLY: Date of last period: _____ Date of last Pap smear: _____ Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
Do you use birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:			

Sexual Health Clinic Client Health History

SOCIAL HISTORY

Do you use tobacco products such as: (check box)

Cigarettes Smokeless tobacco Electronic vapor product Hookah Pipe Chew

Do you: (check box)

Drink alcohol Take street drugs Inject drugs Share needles/equipment

Are you experiencing domestic violence, sexual violence or human trafficking?

Yes No If **yes**, would you like information or help today? Yes No

SEXUAL HISTORY

Have you traveled outside of the United States in the past 60 days? Yes No **If yes, where?**

of sexual partners

in the last 90 days _____

of sexual partners in

the last 12 months _____

of sexual partners

in your lifetime _____

When was the last time you

had sex? _____

In the last 12 months I have had sex with:(check all that apply)

Women Men Transgender Date of last sexual activity: _____

Steady partners (*people you regularly have sex with*) # of **different steady** partners last 3 mons. _____

Casual partners (*people that you don't have sex with very often*) # of **different casual** partners last 12 mons. _____

In the last 12 months my sexual activities include:

Oral sex Give Receive None If **within last 3 months** check here

Anal sex Give Receive None If **within last 3 months** check here

Vaginal sex Give Receive None If **within last 3 months** check here

I use condoms for... **vaginal sex** Always Sometimes Never N/A

I use condoms for... **anal (rectal) sex** Always Sometimes Never N/A

I use condoms for... **oral sex** Always Sometimes Never N/A

Exchanging sex for drugs, money or place to live? Yes No

Having sex while intoxicated or high on drugs? Yes No

Did any of your partners have an STD (including HIV)? Yes No Unsure

Was any of your partners that you had sex with: (check all that apply) **Select if none**

HIV positive IV Drug User Exchanging sex for drugs/money

FEMALES ONLY:

I have had vaginal or anal (rectal) sex with a man who has sex with men Yes No Unsure

SIGNATURE

I have answered all the questions correctly to the best of my knowledge.

Print Name of Client

Signature

Date