Peninsula Community Health Services

HEALTH HISTORY QUESTIONNAIRE (ADULT)

NAME: First: _____ MI: _____ Last: _____

Birthdate (MM/DD/YYYY): ____ / ____ / _____ **Gender Identity:** M / F / Transgender (FTM or MTF) / Other _____

PRIOR / OUTSIDE CARE

Primary Care (PCP): _____

Specialist(s): _____

ER / HOSPITAL in past year? _____

Reason(s): _____

ALLERGIES

NAME	REACTION:
NONE ❒	❒ LATEX
	❒ ANESTHESIA

MEDICATIONS (Prescriptions, over-the-counter meds, supplements)

NAME	DOSE / STRENGTH	DIRECTIONS (AMOUNT / FREQUENCY)	REASON FOR USE

MEDICAL HISTORY (CIRCLE THOSE THAT APPLY TO YOU)

Abnormal PAP smear	Cancer (Type _____)	High Blood Pressure	Seizures
Alcohol Use Disorder	COPD	High Cholesterol	Skin (Acne, Eczema, Psoriasis)
Allergies / Sinus issues	Dementia	HIV/AIDS	Sleep (Apnea, Insomnia)
Anemia	Depression	Kidney (CKD, stone, cyst)	Stroke / TIA
Anxiety	Diabetes (1 / 2 / Insulin)	Liver (cirrhosis, fatty, hepatitis)	Substance Use Disorder(s)
Arthritis / Joint issue / Gout	Ear (Hearing, Ringing, Vertigo)	Osteoporosis	Suicidal thoughts
Asthma	Eye (Vision, Glaucoma, Cataract)	PTSD	Thyroid issue

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Bipolar	Headache (Migraine, cluster)	Reflux / GERD / Ulcer	Tremor (Essential, Parkinson's)
Blood Issue (clot, bleed, genetic)	Heart (A fib, CHF, CAD/MI)	Schizophrenia	Other: _____

OB HISTORY: #Pregnancies _____ #Deliveries____ #Csection ___ #Vaginal ____

SOCIAL HISTORY (HELP US GET TO KNOW YOU BETTER!)

PLACE OF BIRTH: _____ OCCUPATION: _____ HOBBIES: _____

RELATIONSHIP STATUS: Single / Long-term dating / Married / Divorced / Widowed # of kids _____ # of pets _____

WHO PROVIDES YOUR MAIN SUPPORT(S)? Family / Friends / Community of Faith / Sober Group / Co-Worker
Other_____

DO YOU HAVE: **ADVANCE DIRECTIVE / LIVING WILL**? ❒ Yes ❒ No **DURABLE POWER OF ATTORNEY**? ❒ Yes ❒ No

- DO YOU USE **TOBACCO**? ❒ Yes ❒ No ❒ Former TYPE: _____ HOW MUCH? _____
- DO YOU DRINK **CAFFEINE**? ❒ Yes ❒ No ❒ Former TYPE: _____ HOW MUCH? _____
- DO YOU DRINK **ALCOHOL**? ❒ Yes ❒ No ❒ Former TYPE: _____ HOW MUCH? _____
- DO YOU USE **MARIJUANA OR OTHER DRUGS?** ❒ Yes ❒ No ❒ Former TYPE: _____ HOW MUCH? _____

SURGICAL HISTORY

PROCEDURE	YEAR	PROCEDURE	YEAR	GENDER-SPECIFIC	YEAR
❒ Appendix	____	❒ Cardiac / Heart	____	❒ Breast Surgery / Biopsy	____
❒ Back / Spine	____	❒ Hernia	____	❒ Hysterectomy (Reason_____)	____
❒ Bowel / Colon	____	❒ Joint _____(L / R / Both)	____	❒ Tubal Ligation	____
❒ Brain / Head	____	❒ Kidney	____	❒ Prostate (TURP, etc.)	____
❒ ENT (tonsils, tubes, hearing)	____	❒ Thyroid	____	❒ Vasectomy	____
❒ Eye (glaucoma/cataract/retina)	____	❒ Vascular	____	❒ Other:	____
❒ Gallbladder	____	❒ Weight loss	____		

FAMILY HISTORY (CIRCLE THOSE THAT APPLY TO FAMILY MEMBERS)

CONDITION	RELATIVE(S)	CONDITION	RELATIVE(S)	CONDITION	RELATIVE(S)
Alcohol Use Disorder		Depression		Liver Disease	
Allergies		Diabetes		Osteoporosis	
Anemia		Headaches		Seizures	
Asthma / COPD		Heart disease		Stroke / TIA	
Blood Issue		High Blood Pressure		Substance Use	
Cancer (Type_____)		High Cholesterol		Thyroid Disease	
Dementia		Kidney Disease		Other: _____	

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PREVENTION / SCREENING			PLEASE UPDATE IF NOT ALREADY ON FILE			
Item	**Gender**	**Age**	**Year**	**Location**	**Result**	**N/A**
Colonoscopy or FOBT	All	45+ yrs old				❒
Mammogram	Female	40+ yrs old				❒
Pap smear	Female	21+ yrs old				❒
DEXA (Bone Density)	Female	65+ yrs old				❒
COVID-19 vaccine(s)	All	5+ yrs old				❒
Hepatitis B vaccine(s)	All	18+ yrs old				❒
Pneumonia vaccine(s)	All	65+ yrs old				❒
Shingles vaccine(s)	All	50+ yrs old				❒
Tetanus vaccine (Tdap)	All	18+ yrs old				❒
Cholesterol screening	All	40+ yrs old				❒
Hepatitis C screening	All	18+ yrs old				❒
HIV screening	All	18+ yrs old				❒

COMMENTS: (additional information we should know about your health history)

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PATIENT REGISTRATION INFORMATION			
Legal Last Name:			Legal First Name:
First Name Used:			Middle Name: Suffix:
Date of Birth: / /	Sex at Birth: M / F		Previous Name:
Legal Sex: M / F	Mother's Maiden Name:		
Address:			City:
State:	Zip:	Patient Email:	
Home Phone:			Consent to Call? ☐Yes ☐No
Mobile Phone:			Consent to text? ☐Yes ☐No
Work Phone:			How would you like to receive your after-visit summary?
Contact Preference: ☐Home ☐Work ☐Mobile			☐Portal ☐Paper
Who is your usual Primary Care Provider (PCP)?			

Guarantor Information (to whom statements are sent)	
Patient's Relationship to Guarantor:	Address:
Guarantor Name (last, first):	Date of Birth: / /
Home Phone:	Mobile Phone:

Emergency Contact Information	
Name:	Relationship to Patient:
Home Phone:	Mobile Phone:

PCHS Pharmacy Location

☐6th Street ☐ Clare Ave. ☐Port Orchard ☐Belfair ☐Poulsbo ☐Other_____
If other, Address_____

UNIFORM DATA SYSTEMS-PCHS is required to collect the following information from our patients who utilize our services. The following information, when reported, does not include any personal identification information and is confidential.

Marital Status(check one): ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Partner

Language: Do you need an Interpreter? ☐Yes ☐No

Ethnicity (check one): ☐Mexican, Mexican American, or Chicano(a) ☐Puerto Rican ☐Cuban
☐Another Hispanic, Latino(a), or Spanish origin ☐Not Hispanic/Latino(a) ☐Unreported/Refused

Race (check all that apply): ☐Asian Indian ☐Chinese ☐Filipino(a) ☐Japanese ☐Korean ☐Vietnamese
☐Other Asian ☐Native Hawaiian ☐ Other Pacific Islander ☐Guamanian or Chamorro(a) ☐Samoan
☐Black/African American ☐American Indian/Alaskan Native ☐White ☐Unreported/Refused

Income and Household

How many people are in your household?	Check range of your household's annual income: ☐$0 - $15,060 ☐$25,820.01 - $31,200 ☐$15,060.01 - $20,440 ☐$31,200.01 - $36,580 ☐$20,440.01 - $25,820 ☐$36,581 & Higher
Migrant Worker Status ☐Not a farm worker ☐Migrant ☐Seasonal	***Veterans Status*** ☐Veteran ☐Not a Veteran

Questions below apply to 18 years old and above

Sexual Preference: (check) ☐Straight/ Heterosexual ☐Lesbian, Gay, or Homosexual ☐Bisexual ☐Don't Know ☐Other, Please Describe:_____ ☐Choose not to disclose Preferred Prounouns:_____	Do you think of yourself as: (check) ☐Male ☐Female ☐Female-to-Male (FTM)/Transgender Male/Transman ☐Male-to-Female (MTF)/Transgender Female/ Transwoman ☐Gender non-conforming, neither exclusively Male nor Female ☐Other ☐Choose not to disclose

Housing Information

☐own/rent your home without help (NOT HOMELESS) ☐ Staying with Friends /Relatives (DOUBLING UP) ☐Have concerns about your housing and want help(OTHER) ☐Living on the street, outdoor, in a car/travel trailer(STREET) ☐Staying in a treatment facility (TRANSITIONAL) ☐Living in public housing where all tenants get discount rent (PUBLIC HOUSING)	☐Staying in a shelter-short term housing like the mission, YMCA, etc (SHELTER) ☐Living Somewhere not meant to be a home-no running water/heat (OTHER) ☐Having been homeless in the last year and have housing now (TRANSITIONAL) ☐Homebound

How did you hear about us?

☐Advertising (outreach/mobile unit) ☐Primary Care Physician (another provider) ☐Specialist Physician ☐Word of Mouth	☐Patient in the Practice ☐ Hospital ☐Insurance Company ☐Social Media ☐Other:_____

Primary Insurance		**Secondary Insurance**	
☐ I have no insurance, please contact me for options			
Plan Name:		Plan Name:	
Last Name:		Last Name:	
First Name:	Middle Initial:	First Name:	Middle Initial:
ID#	Group#	ID#	Group#
Address:		Address:	
City, State, Zip:		City, State, Zip:	
DOB: / / Sex: M / F		DOB: / / Sex: M / F	
Relationship to Patient:		Relationship to Patient:	

Insurance Authorization

I accept financial responsibility for all my professional services and/or supplies. Payment for services is due at the time rendered unless arrangements have been made.

I authorize my insurance to pay PCHS directly. I am financially responsible for any balance due. I authorize PCHS or the insurance company to release any information for claims unless specifically limited by me in writing.

Patient/Guardian Signature: _____Date:_____

Lifetime Authorization For Billing Medicare *Medicare Recipients Only*

I request that payment for authorized Medicare benefits be made on behalf of Peninsula Community Health Services for any services provided to me.

Patient/Guardian Signature: _____Date:_____

I acknowledge that I have received a copy of my rights and responsibilities. Initial: _____

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HEALTH INSURANCE PORTABLITY ACCOUNTABILITY ACT (HIPAA), PERSONAL HEALTH INFORMATION (PHI), AND HEALTH INFORMATION EXCHANGE (HIE)/COMMUNITY INFORMATION EXCHANGE (CIE)

Privacy Notice Acknowledgment

I acknowledge that I have received the Peninsula Community Health Services' Health Insurance Portability Accountability Act (HIPAA) pamphlet. I have been informed that any questions and/or comments about this notice can be directed to the Privacy Officer, Jennifer Kreidler-Moss, PharmD, CEO, at the following address and phone number:

Peninsula Community Health Services PO Box 960 Bremerton, WA 98337 (360) 377-3776

Notice of Privacy Practices

Peninsula Community Health Services (PCHS) maintains a record of your healthcare services. You may ask us to see a copy of that record. You may ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may request to see your record or get more information by contacting our Health Information Management Department at the following address and phone number:

Peninsula Community Health Services HIM Department PO Box 960 Bremerton, WA 98337 (360) 377-3776

Information Sharing

PCHS works in an integrated health system (i.e. medical, dental, pharmacy, mental health, substance use disorder, enabling/support services). For purposes of continuity and coordination of care, PCHS shares patient information within our own system of care. In order to better meet your healthcare needs, PCHS may also share patient information with community partners such as hospitals, schools, and jails to the extent allowed by law. Where patient privacy laws limit information sharing, PCHS will not share your information unless you give proper consent.

Consent to Participate in Health Information Exchange/Community Information Exchange

PCHS has agreed to participate in a Health Information Exchange (HIE) to share important elements of your care with other healthcare providers and Community Information Exchange (CIE) to coordinate community referrals unless you opt out of the HIE/CIE. Ultimately, participation leads to better, safer, more efficient care for you and your family.

_____ **NO to Participate** The named patient, or their representative, does not consent to the disclosure of the patient's protected health information to HIE and CIE to carry out routine treatment and healthcare operations for continuity of care.

By my signature below I hereby acknowledge that I have been made aware of the availability of the Privacy Notice Acknowledgement, Notice of Privacy Practices, and PCHS' participation in the Health Information Exchange and the Community Information Exchange.

_____ _____
Patient Signature Date

_____ _____
(Print) Guardian/Legal Representative Name Relationship to Patient

_____ _____
Guardian/Legal Representative Signature Date

03/29/2024
Operations

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RELEASE OF VERBAL & WRITTEN INFORMATION AND CONFIDENTIALITY

Patient Name: _____ **DOB:** _____

Consent for the Release of Healthcare Information

I give my permission for the following individuals (include family members and friends) to receive personal health information about me. This permission will be binding until revoked by me.

- _____ Relationship to me: _____
- _____ Relationship to me: _____
- _____ Relationship to me: _____
- _____ Relationship to me: _____

Release Requiring Specific Consent

If you DO NOT WANT any of the following records released, you need to initial and sign below per 42 CFR Part 2 and RCW 70.24.

_____ HIV/AIDS _____ Mental Health _____ Reproductive Care

_____ Sexually Transmitted Diseases _____ Alcohol/Substance Use

Minors: In accordance with Washington State law, a minor patient's signature is required, NOT the parent/guardian signature regarding specific consents described above. □ *Check if patient is a minor.*

**Restrictions – Only clinical records originated through this healthcare facility will be provided unless otherwise specifically requested. This authorization is valid only for the release of information dated prior to and including the date on this form.*

_____	_____	_____
Date	Signature of Patient (minors 13-17) or Representative	Relationship if not Patient

_____

Patient/Parent/Guardian Signature Print Name Date

*I release the providers and staff from all legal responsibility and liability that may arise from the release of this information. I may revoke this consent at any time except when action has been taken. I understand I do not have to sign this authorization in order to get healthcare benefits, which include treatment, payment, or enrollment. However, I do have to sign an authorization form to take part in research studies or to receive health care when the purpose is to create healthcare information for a third party. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. Once PCHS has disclosed health information, the recipient may re-disclose it in some situations. Privacy Laws may no longer protect the information.

***Statement of Confidentiality:** This information has been disclosed to you from records whose confidentiality is protected by Washington State law. State law prohibits you from making any further disclosure of it without the specific written consent of the person whom it pertains or as otherwise permitted by State law. A general (blanket) authorization for the release of clinical records or other information is not sufficient for this purpose. (rv.07_2018)

Expires one year from date authorization is signed, unless specified otherwise: _____

Peninsula Community Health Services

PERMISSION TO RELEASE HEALTH CARE INFORMATION – INCOMING RECORDS

Patient's Full Name:					
Date of Birth: / /		Previous Name (if applicable):			
I HEREBY REQUEST AND GIVE MY PERMISSION TO RELEASE THE FOLLOWING INFORMATION					
INFORMATION TO BE RELEASED TO Peninsula Community Health Services					
PO BOX 960	Bremerton	WA	98337	Phone: 360-377-3776	Fax: 360-874-5595
Reason for Request: ☐Legal ☐Insurance ☐Personal Use ☐Continuing Care ☐Other: _____					
INFORMATION TO BE RELEASE FROM (must provide contact information)					
Name:			Organization:		
Address:					
City:			State:	Zip:	
Phone:			Fax:		
INFORMATION TO BE RELEASED					
☐Information from the past 2 years of care ☐Health information from _____ to _____ ☐Specific health information about _____ ☐Pap ☐Colon/FOBT ☐DEXA ☐Mammogram					
*Restrictions: Only records originating from this healthcare system will be provided unless otherwise specifically requested. This authorization is valid only for the release of information dated prior to and including the date on this form.					
Date:		Signature of patient or representative:			
Relationship if not the patient:					
RELEASE REQUIRING SPECIFIC CONSENT					
My signature above gives you permission to release **ANY and ALL** confidential information relating to testing, diagnosis, or treatment. Per 42 CFR part 2 (See * Statement Below) I understand if I initial any of the following categories of confidential information, it **WILL NOT** be released.					
_____ HIV/AIDS		_____MENTAL HEALTH		_____ SUBSTANCE USE	
_____ SEXUALLY TRANSMITTED DISEASES			_____ REPRODUCTIVE HEALTH		
Minors: In accordance with Washington State law, a minor patient's signature is required, NOT the parent/guardian signature regarding specific consents described above.					
Date:		Signature of patient (minors 13-17) or representative:			
Relationship if not the patient:					

**Records concerning substance use treatment and/or sexually transmitted diseases may NOT be disclosed by you unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by regulation (42 CFR Part 2 and RCW 70.24). An authorization for the release of medical or mental health information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute a substance use patient. Unless otherwise indicated, this release specifically allows the disclosure of mental health/psychological treatment (45 CFR Parts 160 and 164); substance use treatment (42 CFR Part 2); and the Health Insurance Portability Accountability Act of 1996 ("HIPAA") and cannot be disclosed without your written consent unless otherwise provided for in the regulations.*

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party. I understand that: a) I must revoke my permission in writing and may do so by completing and signing the Revocation of Authorization form, available at the medical office; b) if I revoke my permission, it will not affect any actions already taken by PCHS based on this permission; and c) I may not be able to revoke this permission if the purpose of it was to obtain insurance.

Once PCHS has disclosed health information, the recipient may re-disclose it in some situations. Privacy Laws may no longer protect the information.

Expires one year from date authorization is signed, unless specified otherwise: _____