Community Medical Clinic

Hopkinsville, KY Oak Grove, KY **Princeton, KY**

PLEASE RESPOND TO ALL QUESTIONS

Personal Information

Last Name _____ First Name _____ Middle Initial _____

Date of Birth ____/____/_____ Social Security _____-_____-_____

Address _____ PO Box _____

City _____ State _____ Zip _____

Home Phone_____ Cell Phone_____

E-mail address_____ How did you hear about us? _____ Marital

Status: ___ Single Married Divorced ___ Partner ___ Widowed ___ Legally Separated

Race: ____White ___Black ____Hispanic ___Native American ___Asian ___Pacific Islander ___Other

Gender Identity: ___Male ___Female ___Transgender Male/Female to Male ___Transgender Female/Male to Female ___Other

Sexual Orientation: ___Lesbian or Gay ___Straight ___Bisexual ___Something Else ___Don't Know ___Choose not to disclose

Language: ___English ___Spanish ___Other ___Limited English (Translator needed? ___Yes ___No) **Emergency**

Contact

Name_____ Relationship _____ Address

_____ PO Box_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Pharmacy Information

Name_____ Phone_____ Address

_____ City_____ State_____ Zip_____ **Employment**

Information

Employed? _____ Yes _____ No _____Retired

Please check all that apply _____Veteran _____Seasonal Worker _____Migrant Worker _____Public Housing

Health History

Patient Name_____ Today's Date_____

Age_____ Birthdate_____ Date of Last Physical Exam_____

What is the reason for your visit?_____

SYMPTOMS Check symptoms you currently have or have had in the past year.

General
- ☐Chills
- ☐Depression
- ☐Fainting
- ☐Fever
- ☐Forgetfulness
- ☐Headache
- ☐Loss of sleep
- ☐Loss of weight
- ☐Nervousness
- ☐Numbness
- ☐Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in

- ☐Arms ☐Hips
- ☐Back ☐Legs
- ☐Feet ☐Neck
- ☐Hands ☐Shoulders

Genito-Urinary
- ☐Blood in urine
- ☐Frequent urination
- ☐Lack of bladder control
- ☐Painful urination

Gastrointestinal
- ☐Appetite poor
- ☐Bloating
- ☐Bowel changes
- ☐Constipation
- ☐Diarrhea
- ☐Excessive hunger
- ☐Excessive thirst
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Rectal bleeding
- ☐Stomach pain
- ☐Vomiting
- ☐Vomiting blood

Cardiovascular
- ☐Chest pain
- ☐High blood pressure
- ☐Irregular heart beat
- ☐Low blood pressure
- ☐Poor circulation
- ☐Rapid heart beat
- ☐Swelling of ankles
- ☐Varicose veins

Eye, Ear, Nose, Throat
- ☐Bleeding gums
- ☐Blurred vision
- ☐Crossed eyes
- ☐Difficulty swallowing
- ☐Double vision
- ☐Earache
- ☐Ear discharge
- ☐Hay fever
- ☐Hoarseness
- ☐Loss of hearing
- ☐Nosebleeds
- ☐Persistent cough
- ☐Ringing in ears
- ☐Sinus problems
- ☐Vision-Flashes
- ☐Vision-Halos

Skin
- ☐Bruise easily
- ☐Hives
- ☐Itching
- ☐Change in moles
- ☐Rash
- ☐Scars
- ☐Sore that won't heal

MEN only
- ☐Breast lump
- ☐Erection difficulties
- ☐Lump in testicles
- ☐Penis discharge
- ☐Sore on penis
- ☐Other

WOMEN only
- ☐Abnormal PAP smear
- ☐Bleeding between period
- ☐Breast lump
- ☐Extreme menstrual pain
- ☐Hot flashes
- ☐Nipple discharge
- ☐Painful intercourse
- ☐Vaginal discharge
- ☐Other

Date of last menstrual period_____

Date of last PAP smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check conditions you have or have had in the past.

- ☐AIDS
- ☐Alcoholism
- ☐Anemia
- ☐Anorexia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bleeding disorders
- ☐Breast lump
- ☐Bronchitis
- ☐Bulimia
- ☐Cancer
- ☐Cataracts
- ☐Chemical Dependency
- ☐Chicken Pox
- ☐Diabetes
- ☐Emphysema
- ☐Epilepsy
- ☐Glaucoma
- ☐Goiter
- ☐Gonorrhea
- ☐Gout
- ☐Heart Disease
- ☐Hepatitis
- ☐Hernia
- ☐Herpes
- ☐High Cholesterol
- ☐HIV Positive
- ☐Kidney Disease
- ☐Liver Disease
- ☐Measles
- ☐Migraine Headaches
- ☐Miscarriage
- ☐Mononucleosis
- ☐Multiple Sclerosis
- ☐Mumps
- ☐Pacemaker
- ☐Pneumonia
- ☐Polio
- ☐Prostate Problem
- ☐Psychiatric Care
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Stroke
- ☐Suicide Attempt
- ☐Thyroid Problems
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Typhoid Fever
- ☐Ulcers
- ☐Vaginal Infections
- ☐Venereal Disease

MEDICATIONS List current medications	**ALLERGIES** To medications or substances
Pharmacy Phone	

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
Sisters					Heart Disease Stroke	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcom

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please give approximate dates_____

SERIOUS ILLNESS	DATE	OUTCOME

HEALTH HABITS Check which substances you use and describe how much you use each substance.

	Caffenine	
	Tobacco	
	Street Drugs	

OCCUPATIONAL CONCERNS Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date Signed

Community Medical Clinic

Hopkinsville Oak Grove Princeton

PERMISSION FOR TREATMENT/NOTICE OF RIGHTS AND PRIVACY

Name _____
Please Print

Date of Birth _____

Permission is hereby granted to the staff of Community Medical Clinic to render treatment and /or services to the above named patient.

I understand that there is a copy of the Notice of Privacy Practices available upon request.

I have had the opportunity to discuss this information and understand my rights.

_____ _____
Name of Individual Signing Authorization Date Signed

If not signed by the client, specify basis for Authority to sign:

___ Parent ___Spouse ___ Personal Representative

___ Other (Describe Authority to Sign) _____

_____ _____
Staff Signature Date Signed

Sliding Scale and Patient Monthly Income

Patient Name:_____
Family Household Monthly Income:_____
Refused to supply family household monthly income: ☐
Number of Family Members in Household:_____
Are you interested in applying for the Sliding Fee Scale?_____

Question: What is the Sliding Fee Scale?
Answer: The scale is based on income and household size. Patients can receive as much as 44% to 100% off the patient's portion of the visit.

Once you are interested in applying for the Sliding Fee Scale, please return to us your proof of income and the number of people living in your household. The Sliding Fee Scale cannot start until we receive your information back and it has been approved. Also, we cannot back date your information and if approved it will take effect on that day.

Applicants must provide proof of family household income: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

Applicants must provide: Size of their family household. Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

Those with health insurance, except Medicaid, can still see benefits from the Sliding Fee Scale. For example, if there is a lapse in your insurance policy or with high deductible/out of pocket from most insurance plans the slide discount will cover where your insurance didn't.

If you elect to not choose the Sliding Fee Scale we still need to record your monthly income into our database. If you choose to not share your income with us then please mark the box above so that we have proof we did ask you for this information.

Please let us know if you have any questions in regards to how the Sliding Fee Scale works and how it can benefit you and your family.

Community Medical Clinic

FEE ELIGIBILITY RECORD

Name _____ Date _____

Please Print Clearly

Responsible Party

_____

Name Relationship Phone

_____

Address City State Zip

Insurance Information

_____

Name of Insurance (Primary) Employer

_____

Name of Insured Insured's DOB Relationship

_____

ID Number Group Number Effective Date

_____

Name of Insurance (Secondary) Employer

_____

Name of Insured Insured's DOB Relationship

_____

ID Number Group Number Effective Date

By signing below, the responsible party accepts responsibility for the fee for all service not covered by a third party fund source. I also understand that it is by responsibility to notify Community Medical Clinic of any changes with my insurance or other third party funding sources, including discontinuations of additions.

_____ _____

Responsibility Party Date Signed

_____ _____

Staff Signature Date Signed

Release of Information (To)

I, _____ authorize the following from my Protected Health Information:

__Health & Physical
__Medication History
__Height/Weight/Vitals
__Length of Treatment
__Discharge Summary
__Other:_____

__Lab Reports
__Physical Health Evaluation
__Treatment Notes
__Diagnosis

_____

_____

to be disclosed to _____

_____

I understand the purpose for releasing this information is for:_____

_____

(be as specific as possible)

I understand I may refuse to sign this authorization and my refusal will not prevent my receiving services.

I understand I may revoke this authorization, at anytime, if requested in writing to Pennyroyal Health Care Services, except if Pennyroyal has already undertaken an action in reliance upon it, and that in any event this consent expires automatically as follows:

_____

(Specify date, event, or condition)

or in one year from the date of this authorization, whichever is sooner.

I understand pursuant to KRS 304.17A-555-My Protected Health Information, released under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the redisclosure.

I have read and understand this authorization.

_____ _____

(Individual Signing Authorization) (Date Signed)

If not signed by the client, specify basis for authority to sign:___Parent ___Spouse ___Personal Representative
___Other:_____(Describe Authority to Sign)

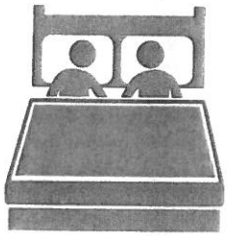
_____ _____

Staff Signature and Title) (Date Signed)

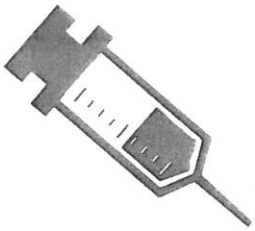
HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV Can Be Transmitted By



Sexual Contact



Sharing Needles to Inject Drugs

Mother to Baby during pregnancy, birth, or breastfeeding

HIV Is NOT Transmitted By

Air or Water

Saliva, Sweat, Tears, or Closed-Mouth Kissing

Insects or Pets

Sharing Toilets, Food, or Drinks

Protect Yourself From HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Limit your number of sex partners.
- Don't inject drugs, or if you do, don't share needles or works.

- If you are at very high risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

Keep Yourself Healthy And Protect Others If You Are Living With HIV

- Find HIV care. It can keep you healthy and greatly reduce your chance of transmitting HIV.
- Take your medicines the right way every day.
- Stay in HIV care.

- Tell your sex or drug-using partners that you are living with HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

For more information please visit www.cdc.gov/hiv

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National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

CDC

WHAT YOU SHOULD KNOW ABOUT HIV & AIDS

WHAT IS AIDS?

AIDS is the Acquired Immune Deficiency Syndrome – a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections, this person becomes ill. These infections can eventually kill a person with AIDS.

WHAT CAUSES AIDS?

The human immunodeficiency virus (HIV) causes AIDS. Early diagnosis of HIV infection is important! If you have been told that you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Free or reduced cost anonymous and confidential testing with counseling is available at every local health department in Kentucky. After being infected with HIV, it takes between two weeks to six months before the test can detect antibodies to the virus.

HOW IS THE HIV VIRUS SPREAD?

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen, rectal fluids or cervical/vaginal secretions are exchanged.
- Sharing syringes, needles, cotton, cookers and other drug injecting equipment with someone who is infected.
- Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985).
- An infected mother passing HIV to her unborn child before or during childbirth, and through breast feeding.
- Receipt of transplant, tissue/organs, or artificial insemination from an infected donor.
- Needle stick or other sharps injury in a health care setting involving an infected person. Infections can sometimes be prevented by taking post-exposure prophylaxis anti-retroviral drugs. Strict adherence to universal precautions is the best way to prevent exposures.

YOU CANNOT GET HIV THROUGH CASUAL CONTACT SUCH AS:

- Sharing food, utensils, or plates
- Touching someone who is infected with HIV
- Hugging or shaking hands
- Donating blood or plasma (this has NEVER been a risk for contracting HIV)
- Using public rest rooms
- Being bitten by mosquitoes or other insects
- Using tanning beds (always clean before and after use)

HOW CAN I PREVENT HIV/AIDS?

- Do not share needles or other drug paraphernalia.
- Do not have sexual intercourse except with a monogamous partner whom you know is not infected and who is not sharing needles. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams, and water based lubricants every time you have sex.
- Educate yourself and others about HIV infection and AIDS.

PREGNANCY AND HIV/AIDS

- Mothers can pass HIV infection to their babies during pregnancy, labor and delivery, and by the child ingesting infected breast milk.
- Without treatment, about 25% (1 out of 4) of the babies born to HIV infected women will get HIV.
- Medical treatment for the HIV infected woman during pregnancy, labor, and delivery can reduce the chance of the baby getting HIV from its mother to less than 2% (less than 2 out of 100).
- An HIV infected mother should not breastfeed her newborn baby.

WHAT IS UNSAFE SEX?

- Vaginal, anal, or oral sex without using a condom or dental dam
- Sharing sex toys
- Contact with HIV infected blood, pre-ejaculation fluid, semen, rectal fluids or cervical/vaginal secretions

WHAT IS "SAFER" SEX?

- Abstinence (not having sex of any kind)
- Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs
- Using either a male or female condom or dental dam (for oral sex)

How to use a latex condom:

1. Use a new latex condom every time you have sex.
2. The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation (semen) fluid. Air bubbles should be smoothed out.
3. Use plenty of WATER-BASED lubricants such as K-Y Jelly, including a drop or two inside the condom, before and during intercourse. DO NOT USE oil-based lubricants such as petroleum jelly, mineral oil, vegetable oil, Crisco, or cold cream.
4. After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.
5. Throw away the used condom into a garbage can and wash hands.

Remember: You can't tell whether or not someone has HIV just by looking at them!

IS TREATMENT AVAILABLE IF I ALREADY HAVE HIV/AIDS?

After being infected with HIV, it takes between two weeks to six months before antibody tests can detect HIV. **Early diagnosis of HIV infection is important!** If you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment.

GETTING TESTED FOR HIV:

If you have never been tested for HIV, you should be tested at least once. Free anonymous and confidential rapid antibody testing and counseling are available at every health department in Kentucky. Centers for Disease Control and Prevention (CDC) recommends being **tested at least once a year if you do things that can transmit HIV.** These include:

- Injecting drugs or steroids with used injection equipment
- Having sex with someone who has HIV or any sexually transmitted disease (STD)
- Having more than one sex partner since your last HIV test
- Having a sex partner who has had other sex partners since your last HIV test
- Having sex for money or drugs (prostitution- male or female)
- Having unprotected sex or sex with someone who has had unprotected sex
- Having sex with injecting drug user(s)
- Having had a blood transfusion between 1978 and 1985
- Pregnant women or women desiring to become pregnant

This agency provide quality services to all patients, regardless of HIV status.

IF YOU NEED MORE INFORMATION CALL:
Kentucky HIV/AIDS Program 502-564-6539
The National AIDS Hotline 1-800-342-AIDS
Your local health department's HIV/AIDS Coordinator

CHFS- EPI
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