

**BIRTH & FAMILY CLINIC**

21911 76<sup>th</sup> Ave. W., Suite 110 Edmonds, WA 98026  
Phone: 425-640-4950 Fax: 425-640-4958

**Acknowledgment of Receipt of Privacy Notice**

\_\_\_\_\_  
Patient Name (Please PRINT)

\_\_\_\_\_  
Date of Birth

1. With my initials below, I acknowledge that I was offered and/or provided with a copy of the Notice of Privacy Practices for Birth & Family Clinic.

Initial Here: [       ]

2. I authorize Birth & Family Clinic to contact me with my **CONFIDENTIAL** information regarding treatment or test results at the following numbers:

*Please leave at least one number where we could leave you a message.*

- Home Number: (       ) Voicemail OK?  Yes  No
- Cell Number: (       ) Voicemail OK?  Yes  No
- Work Number: (       ) Voicemail OK?  Yes  No

3. I authorize Birth & Family Clinic to discuss my protected health information, including medical history, current conditions, treatment, and test results with the following individuals:

- Patient Only**
- Spouse or Significant Other**  
Name: \_\_\_\_\_
- Parent(s)**  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_
- Other**  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

4. I authorize Birth & Family Clinic to discuss my billing information with the above noted individuals.

- Yes  No

**X** \_\_\_\_\_  
Signature Relationship to Patient Date

This authorization is valid for one year (1) following the date signed above unless withdrawn in writing to Birth & Family Clinic.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Last First MI.

**Reason for visit or current medical problems:**  
 (Include date of onset or injury)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Women Only – Menstrual History & Pregnancies**

Age at first period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_  
 Date of last pap: \_\_\_\_\_  
 Date of last period: \_\_\_\_\_  
 Frequency (for example 28 days): \_\_\_\_\_  
 Birth control method: \_\_\_\_\_  
 Total pregnancies # \_\_\_\_\_  
 Deliveries: vaginal # \_\_\_\_\_ c-section # \_\_\_\_\_  
 Miscarriages # \_\_\_\_\_ Terminations # \_\_\_\_\_

**Past Medical Problems:** (Include year)

None  No Changes

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgeries or Hospitalizations:** (Include year)

None  No Changes

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications:**

*Include any non-prescription drugs, vitamins, supplements, and birth control pills.*  
 (Include frequency and dose)

None  No changes

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:**

(List the drug and the reaction you had)  
 None  No changes

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:** (List the family member and the age diagnosed)  No changes

Alcoholism _____	Hay Fever _____	Obesity _____
Asthma _____	Heart Disease _____	Osteoporosis _____
Breast Cancer _____	High Blood Pressure _____	Ovarian Cancer _____
Colon Cancer _____	High Cholesterol _____	Prostate Cancer _____
Diabetes _____	Mental Illness (list type) _____	Stroke _____
Glaucoma _____	Migraine _____	TB _____

**Social History**  No changes

Marital Status:  Single  Married  Separated  Divorced  Widowed  Live with partner

Children: (List first name and birth year) \_\_\_\_\_

Language: \_\_\_\_\_ Religion: \_\_\_\_\_

Education Completed:  Grade  H.S.  Voc.  College  Advanced Degree Other: \_\_\_\_\_

Employment Status:  Working  Unemployed  Retired  Disabled Occupation: \_\_\_\_\_

**Risk Factors**  No changes

Tobacco:  Never  
 Year started: \_\_\_\_\_ Year Quit: \_\_\_\_\_  
 Cigarettes: \_\_\_\_\_ packs/day  Cigars: \_\_\_\_\_ #/week  
 Chew: \_\_\_\_\_ cans/day  Pipe  
 Passive smoke exposure:  Current  Past

Alcohol:  No  Yes  
 Type \_\_\_\_\_ # Drinks \_\_\_\_\_/day  
 Drugs:  No  Yes Type \_\_\_\_\_  
 HIV high risk behavior:  No  Yes  
 Caffeine:  No  Yes Drinks/day \_\_\_\_\_  
 Exercise Type: \_\_\_\_\_ Times \_\_\_\_\_/week

**X** \_\_\_\_\_  
 SIGNATURE DATE

## Review of Systems

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Circle any symptoms you are currently experiencing:     None

<p><b>General</b> fevers chills drenching night sweats loss of appetite fatigue unexpected weight loss trouble sleeping severe snoring daytime sleepiness</p> <p><b>Eyes</b> loss of vision double vision eye irritation blurred vision eye pain eye discharge light sensitivity</p> <p><b>Ears, Nose &amp; Throat</b> ringing in the ears ear discharge earache decreased hearing nasal congestion nasal discharge nosebleeds face or jaw pain difficulty swallowing hoarseness sore throat</p> <p><b>Cardiovascular</b> difficulty breathing at night fainting or near fainting chest pain palpitations or racing heart short of breath with exertion swelling in extremities difficulty breathing lying down</p>	<p>calf pain with walking recent weight gain</p> <p><b>Respiratory</b> cough short of breath coughing up blood chest pain with deep breaths wheezing (asthma) excessive mucus or phlegm</p> <p><b>Gastrointestinal</b> heartburn indigestion vomiting vomiting blood nausea abdominal pain abdominal bloating diarrhea change in bowel movements constipation black tarry stools rectal bleeding/blood in stools</p> <p><b>Genitourinary</b> blood in urine urinary frequency urinary urgency burning or pain with urination urinary incontinence genital sores decreased sex drive</p> <p><b>Women Only-Genitourinary</b> hot flashes pain with intercourse irregular or missed periods heavy periods prolonged periods painful periods</p>	<p>spotting vaginal discharge pelvic pain</p> <p><b>Men Only-Genitourinary</b> trouble starting urination weak or narrow urine stream dribbling after urination incomplete emptying frequent nighttime urination discharge from penis problems with erections testicular pain or lump</p> <p><b>Musculoskeletal</b> muscle cramps joint pain joint swelling back pain stiffness general weakness muscle aches</p> <p><b>Skin/Breasts</b> excessive perspiration suspicious mole or growth change in hair or nails non-healing sores dry skin itching rash breast pain breast lump nipple discharge</p> <p><b>Neurological</b> trouble concentrating poor balance or coordination headaches facial weakness</p>	<p>numbness or tingling slurred speech falling down visual disturbances seizures arm or leg weakness sensation of spinning tremors loss of consciousness confusion uncontrolled movements dizziness poor memory</p> <p><b>Mental Health</b> fears or phobias anxious mood thoughts of suicide depressed mood thoughts of violence to others frightening visions or sounds</p> <p><b>Endocrine</b> excessive hunger intolerance to cold intolerance to heat excessive urination excessive thirst</p> <p><b>Blood</b> enlarged glands prolonged bleeding excessive or easy bruising</p> <p><b>Allergy &amp; Immunology</b> persistent infections hives seasonal allergies possible HIV exposure</p>
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