MEDICAL HISTORY

Name: _____ Date of birth: _____

Primary Care Physician name & number: _____

Reason for visit: _____

Check any problems you have had and the date of diagnosis: □ No history of problems

Gynecology: □ Fibroids □ Adenomyosis □ Endometriosis □ Cyst □ PCOS □ Lichen sclerosis □ Cervical dysplasia □ Painful intercourse □ Cancer □ Prolapse □ Other/date _____

Std: □ Hpv □ Chlamydia □ Gonorrhea □ Herpes □ Hepatitis □ HIV □ Syphilis □ Genital warts _____

Breast: □ Cancer □ Mass □ Biopsy _____

Heart: □ High blood pressure □ Heart disease □ Mitral valve □High Cholesterol □ Other _____

Digestive Disorder: □ Reflux □ IBS □ Cancer □ Other/Date _____

Endocrine: □ Diabetes □ Thyroid disease □ Other/Date _____

Blood: □ Anemia □ Blood Transfusion □ Clotting disorder □ Sickle cell trait □ Other/Date _____

Musculoskeletal: □ Arthritis □ Osteopenia/Osteoporosis □ Lupus □ Scoliosis □ Other/Date _____

Neurological: □ Migraines □ Seizures □ Stroke □ Glaucoma □ MS □ Other/Date _____

Psychiatric: □ Anxiety □ Depression □ Bipolar □ ADD □ Eating disorder □ OCD □ Other/Date_____

Respiratory: □ Asthma □ COPD □ Lung disease □ Apnea □ Other/Date _____

Skin Disorders: □ Skin Cancer □ Acne □ Eczema □ Hirsutism □ Psoriasis □ Other/Date _____

Urology: □ Urinary incontinence □ Kidney stone □ Interstitial Cystitis □ Other/Date _____

Surgical History: □ **No Surgeries**

Year	Type of Surgery

Year	Type of Surgery

Medications: (Prescribed & Over-The-Counter) □ **No Medications**

Name	Dosage	Frequency

Name	Dosage	Frequency

Allergies To Medications/Foods: □ **No known allergies**

Medication	**Reaction**

Medication	**Reaction**

Allergy to: □ Latex □ Iodine/Shellfish □ Other _____

Immunizations:

Have you gotten the Gardasil® Vaccine to prevent the Human Papilloma Virus?
□ Yes □ No □ Yes, but I haven't completed the series □ No, I am over 26yo □ No, but I am interested

Social History:
Tobacco use: □ Never □ Former, amount of years _____ □ Current, □ Every day □ Some days
Alcohol: □ None □ Occasional □ Moderate □ Heavy
Education level: □ High school □ 2-year College □ 4-year College studies □ Post-Graduate
Exercise: □None □ Occasional □ Moderate □ Heavy
Relationship history: □ Single □ Married □ Widowed □ Divorced □ Separated □ Domestic partner
Occupation: _____
Living arrangement: □ Live alone □ Live with others **Number of children**: _____
Caffeine intake: (coffee, teas, sodas & etc.) □ None □ Occasional □ Moderate □ Heavy
Sexual Orientation: □ Heterosexual/Straight □ Lesbian/Gay/Homosexual □ Bisexual □ Something else
Are you currently sexually active? □ Yes □ No **Do you use condoms?** □ Always □ Usually □ No
Diet: □ Regular □ Vegetarian □ Vegan □ Gluten free □ Other _____
Stress Level: □ Low □ Medium □ High
Would you like to discuss abuse (Emotional, Physical, or Sexual)? □ Yes □ No □ No Abuse

Family History: (Use Abbreviations) □ Family History Unknown □ Adopted □ No Family History

Disease	Relationship to Patient	Age of Onset	Relationship to Patient	Age of Onset
High blood pressure				
Heart condition				
Stroke				
Blood clot/disorder				
Diabetes				
Thyroid condition				
High cholesterol				
Breast cancer				
Ovarian cancer				
Colon cancer				
Cancer (other)				
Other Condition				

Use Abbreviations For relationship
M (Mother)
F (Father)
B (Brother)
S (Sister)
MGM (Maternal Grandmother)
PGM (Paternal Grandmother)
MGF (Maternal Grandfather)
PGF (Paternal Grandfather)
MA/PA (Maternal/Paternal Aunt)
MU/PU (Maternal/Paternal Uncle)

Reproductive history: Age period first started: _____ First day of last cycle _____

Flow: □ Light □ Moderate □ Heavy **Duration of bleeding: ____** days**, Frequency of period:** Every____ days

□ Post-menopausal at age ___ □ Hysterectomy □ No cycles due to birth control

Current Birth Control Method: □ Condoms □ Nuvaring □ Patch □ Depo shot □ Diaphragm □ Abstinence
□ Rhythm □ Withdraw □ Tubal □ Essure □ Vasectomy □ Nexplanon □ Desire Pregnancy □ Infertile
□ Not Necessary □ None □ Birth control pill (Name of pill: _____)
□ IUD (□ Mirena □ Skyla □ Paragard □ Liletta □ Kyleena) Year inserted _____

Last Pap Smear: _____ Results □ Normal □ Abnormal _____
Last Mammogram: _____ Results □ Normal □ Abnormal _____
Last Colonoscopy: _____ Results □ Normal □ Abnormal _____
Last Bone density scan: _____ Results □ Normal □ Abnormal _____

Pregnancy History: Total number of pregnancies: _____ Live Births: _____ Full term: _____ Premature ____
Miscarriages: _____ Ectopic Pregnancies: _____ Voluntary Abortions:_____ Living Children:_____

Review of systems

Name: _____ DOB: _____ Date: _____

Current Problems:

□ No Current Problems

Constitutional (overall): □ Fever □ Fatigue □ Significant weight gain & amount ____
□ Significant weight loss & amount ____

Skin: □ Abnormal mole □ Rash

Eyes: □ Irritation □ Vision changes

HENT: □ Hearing loss □ Ear pain □ Nose/sinus problems □ Sore throat □ Snoring □ Dry mouth
□ Mouth ulcer

Respiratory: □ Cough □ Sputum production □ Bloody sputum □ Wheezing

Cardiovascular: □ Chest pain □ Irregular heartbeats □ Shortness of breath □ Difficulty breathing
□ Edema

Gastrointestinal: □ Heartburn □ Indigestion □ Difficulty swallowing □ Nausea □ Vomiting
□ Abdominal pain □ Bowel movement changes □ Diarrhea □ Constipation
□ Rectal bleeding

Genitourinary: □ Blood in urine □ Abnormal bleeding □ Heavy Periods □ Painful periods
□ Lower side back pain □ Difficulty urinating □ Urinary frequency □ Urinary urgency
□ Pain with urination □ Frequent urination at night □ Incontinence □ Rash □ Lesion
□ Vaginal discharge □ Vaginal itching □ Vaginal odor

Endocrine: □ Increased hunger □ Increased thirst

Menstrual cycle: □ Mood swings □ Irritability □ Tension □ Anxiety □ Depressed mood □ Breast pain
□ Breast tenderness □ Bloating

Menopausal: □ Hot flashes □ Night sweats □ Vaginal dryness □ Impaired memory
□ Impaired concentration

Sexual Problems: □ Decreased sexual desire □ Orgasmic dysfunction □ Painful intercourse

Musculoskeletal: □ Muscle aches □ Muscle weakness □ Joint pain □ Back pain □ Swelling in legs

Neurological: □ Loss of consciousness □ Weakness □ Numbness □ Seizures □ Dizziness
□ Frequent or severe headaches □ Migraines □ Restless legs

Psychological: □ Depression □ Alcoholism □ Sleep disturbance

Hematology: □ Swollen glands □ Easy bruising □ Excessive bleeding

Allergy/Immune: □ Runny nose □ Itching □ Hives □ Frequent sneezing

FERN L. GRAPIN, M.D., P.C.

FERN L. GRAPIN, M.D.
2871 DUKE STREET, ALEXANDRIA, DR 22314

Patient Demographics

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security#:_____

Address: _____ Employer Name: _____

City: _____ Race: _____ Ethnicity: _____

State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Spouses Name: _____

Cell Phone:_____ Email Address: _____

Work Phone: _____ May we contact you about your confidential health info by e-mail?: Yes No

Primary Care Physician: _____ Primary Care Phone: _____

I hereby authorize Fern L. Grapin, M.D. to obtain/download my medical history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing. Initial: _____ Date:_ _____

Preferred Pharmacy Name/Address: _____Pharmacy Number: _____

Contact Preference: (Please Circle) Home Work Cell Email Portal

Patient Insurance Information

Primary Insurance

Insurance Company Name:_____
Policy Number: _____
Group Number:_____
Subscriber's Name: _____
Subscriber's Relation to Patient: _____
Subscriber's Date of Birth: _____
Subscriber's Social Security#: _____

Secondary Insurance

Secondary Insurance Name:_____
Policy Number: _____
Group Number: _____
Subscriber's Name: _____
Subscriber's Relation to Patient: _____
Subscriber's Date of Birth: _____
Subscriber's Social Security#: _____

Emergency Contact & Consent to Share Information

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

AUTHORIZATION

I hereby authorize the release of all medical information necessary for the processing of insurance claims. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to Fern L. Grapin, M.D. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Fern L. Grapin for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for payment denied by my insurance due to lack of referral and/or inaccurate insurance information. I understand that I am responsible for obtaining referrals, if necessary, prior to my appointment. I understand that I am responsible for payment of any portion of my bill not paid by my insurance company, including those deemed medically unnecessary by my insurance. I also understand that if my account is turned over for collections a $25 fee will be assessed to my account. This fee is non-negotiable. **I understand that if my account is turned over for collections I will not be able to schedule any future appointments until the debt is paid in full. Dr. Grapin's office will impose a late cancellation fee of $25 for appointments not cancelled within 24 hours in advance or a no-show fee of $50 if you fail to show up or cancel your appointment.**

Patient Signature: _____ Date: _____

FERN L. GRAPIN, M.D., P.C.

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner, (check all that apply)
Please fill in phone numbers accurately on all lines that apply.

☐ **Home Telephone _____**

- ☐ **O.K. to leave message with detailed information.**
- ☐ **Leave message with call back number only**
- ☐ **Preferred method of communication**

☐ **Work Telephone _____**

- ☐ **O.K. to leave message with detailed information**
- ☐ **Leave message with call back number only**
- ☐ **Preferred method of communication**

☐ **Cell Telephone _____**

- ☐ **O.K. to leave message with detailed information**
- ☐ **Leave message with call back number only**
- ☐ **Preferred method of communication**

☐ **Written Communication _____**

- ☐ **O.K. to mail to my home address**

☐ **Other i.e.-Mother, Father, Spouse or Significant other**
Name:_____ _____Relationship:_____

- ☐ **O.K. to leave message with detailed information**
- ☐ **Leave message with call back number only**

☐ **Emergency Contact: _____ Relationship:_____**
Phone Number:_____

_____ _____
Patient Name (Printed) **Date of Birth**

_____
Patient Signature **Date**

In general, the HIPPA privacy rule gives individuals the right to request a restriction or uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, i.e. sending correspondence to an office instead of a residence.

FERN L. GRAPIN, M.D., P.C.

FERN L.GRAPIN, M.D.
2871 Duke Street
Alexandria, VA 22314

CONSENT AGREEMENT
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please Read The Following Statements Carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Privacy Notice: You have the right to read our Privacy Notice before you decide whether to sign this Consent. Our Privacy Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Privacy Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Privacy Notice. If we change our privacy practices, we will issue a revised Privacy Notice, which will contain the changes. Those changes may apply to any of your protect health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Thank you for your continued confidence in our practice and for supporting our new requirement. The following is a statement that allows us the necessary latitude to work within the new requirements.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Privacy Notice. I understand that, by signing this Consent form, **I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.**

Signature: _____ Date: _____

FERN L. GRAPIN, M.D., P.C.

FERN L. GRAPIN, M.D.
2871 Duke Street
Alexandria,VA 22314

HIPPA PRIVACY NOTICE

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review this carefully.
The privacy of your health information is important to us.

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, **(The Health Insurance Portability and Accountability Act of 1996) (HIPPA),** mandates that we issue this new **Privacy Notice** to our patients. This notice to our patients meets all current requirement as it relates to **Standards for Privacy of Individually Identifiable Health Information (IIHI)**; affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated, **Consent Agreement**. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health care operations (TPO).

Our Privacy Notice informs you of our use and disclosure of your **Protected Health Information (PHI),** defined as: "any information whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual."

Our office will use or disclosure your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dates Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted; we exercise a "minimum necessary information" restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization form.

You, as our patient may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of maters already in process as a result of period use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed.

If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgement with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

In limited circumstances, the Privacy Standard permits, but does not require covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include; emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities related to national defense and security. There are specific state laws that require disclosure of health care information related to Hepatitis C, AIDS, and any other reportable disease. Where the state laws are more stringent than HIPPA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgements to decide whether to disclose any information, reflecting our own policies and ethical principles.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Vicky Morales
Telephone: 703-751-3031
Fax: 703-778-5999
Address: 2871 Duke Street
Alexandria, VA 22314