

## 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	Use Abbreviations For relationship
High blood pressure					<b>M</b> (Mother)
Heart condition					<b>F</b> (Father)
Stroke					<b>B</b> (Brother)
Blood clot/disorder					<b>S</b> (Sister)
Diabetes					<b>MGM</b> (Maternal Grandmother)
Thyroid condition					<b>PGM</b> (Paternal Grandmother)
High cholesterol					<b>MGF</b> (Maternal Grandfather)
Breast cancer					<b>PGF</b> (Paternal Grandfather)
Ovarian cancer					<b>MA/PA</b> (Maternal/Paternal Aunt)
Colon cancer					<b>MU/PU</b> (Maternal/Paternal Uncle)
Cancer (other)					
Other Condition					

**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.**  
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: \_\_\_\_\_





## 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.







**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:** \_\_\_\_\_



## 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 matters 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 PHI. 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: Denise Contreras  
Telephone: 703-751-3031  
Fax: 703-778-5999  
Address: 2871 Duke Street  
Alexandria, VA 22314