Grand View Medical Practices OB/GYN Adult Health History Form

Name: _____ Date of Birth: _____
Reason for Today's Visit: _____
Any Current Symptoms?: _____
Where were you receiving care before?: _____
When were you last seen there?: _____

Do you feel safe at home?: Circle one: Yes No
Preferred Laboratory?: Circle one: Grand View LabCorp Quest Other:_____
Preferred Pharmacy: _____ City:_____ Phone:_____
Would you like Access to GVH online Patient Portal?: Circle One: Yes No

Allergies to Medications:

Medication	**Reaction**
_____	_____
_____	_____
_____	_____

Current Medications You Take:

Medication	**Dose**	**Frequency**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OB/GYN History:

Total Number of Pregnancies: _____ Live Births: _____ Living Children:_____
Still Births: _____ Miscarriages: _____ Terminations: _____
Premature Births (less than 36 weeks): _____ Fetal Demise: _____
Any Complications?: _____

First Day of Last Menstrual Period: _____
Age at First Period: _____
Age at End of Periods (menopause): _____
Last Pap Smear (age 21+): _____
Last Mammogram (age 40+): _____

(continued..)

Grand View Medical Practices OB/GYN Adult Health History Form

Last Dexascan (age 65+): _____
Have you ever had the HPV vaccine (Gardasil)?: Yes No **If so, When?**: _____
Have you ever had a Colonoscopy? (age 45+): Yes No **If so, When?: _____**

Past Medical History: (Please check off all that apply)

- Anemia
- Asthma
- Allergies
- Alcohol/Drug Abuse
- Anxiety
- Arthritis
- Bowel Disease
- Blood Clots
- Cancer: Type:____
- Depression
- Diabetes
- Eating Disorder
- Heart Disease
- High Blood Pressure
- High Cholesterol
- HIV
- Headaches
- Kidney Problems
- Liver Disease
- Lung Disease
- Osteoporosis
- Seizure Disorder
- Sexually Transmitted Disease
- Sleep Apnea
- Skin Condition
- Thyroid Disorder
- Psychiatric Disease
- Stroke
- Ulcer Disease
- Other (explain): _____
  - _____
  - _____

Past Surgical History: (Please list all surgeries with approximate date)

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History: (Please check all that apply)

Mother	Father	Sibling	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	
							Alzhiemer's
							Asthma
							Autoimmune Disease
							Aneurysm
							Bleeding/Clotting Disorder
							Brain Tumor
							Cancer (list type)
							Colon Polyps
							Diabetes
							Depression/Anxiety
							Glaucoma
							Heart Disease
							Lung Disease
							Multiple Sclerosis
							Stroke
							Seizures
							Other (explain)

Social History:

Who lives in your home with you?: _____

Any children?: _____

Marital Status: _____

Have you ever smoked any tobacco products?: Circle One: Yes No

If so, how many cigarettes per day?: _____ How many years?: _____

Quit Date?: _____

Tobacco Type: Circle all that apply: Cigarettes Cigar Chew Snuff Vape

Do you drink any alcohol? Circle One: Yes No

How Much per week?: _____

Have you ever used any recreational drugs? Circle One: Yes No

If so, what kind? Circle all that apply:

Marijuana Crack/Cocaine Heroin Amphetamines Hallucinogens Tranquilizers Sedatives Opiates Painkillers Club/Designer Drugs Inhalants IV Drugs Methamphetamines Prescription Drugs

Quit Date?: _____

What is your occupation?: _____

How would you rate your diet?: Circle One: Good Fair Poor

Are you on a specific diet type?: Circle any that apply:

No Low Fat Low Sodium Low Carb Diabetic Gluten Free Vegetarian Vegan Paleo

Would you like advice on your diet?: Circle One: Yes No

Do you drink any Caffeine?: Circle One: Yes No

How Much per day?: _____

Do you Exercise regularly?: Circle One: Yes No

How often per week?: _____

What type of exercise?: _____

Any Hobbies or Acitivities?: _____

Have you ever been sexually active?: Circle one: Yes No

Are you currently sexually active?: Yes No

Current number of Partners?: _____

Preferred Partner is/are/have been: Male Female Both

Contraception Type: Condoms Depo-Provera Diaphragm Foam IUD Oral Contraceptive Pill Patch Ring Tubal Ligation Vasectomy Abstinence Infertility Mini Pill Withdraw Other:_____

Any Recent Travel? _____

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PATIENT INFORMATION

Name (Last, First, Middle)	Employer Name
Date of Birth: Sex: ☐ M ☐ F ☐ Unk	Employer's Address
Address	Employer's Phone #
City State Zip	Employer Status ☐ Full time ☐ Part time ☐ Retired ☐ Active Military ☐ Self Employed ☐ Unemployed
Email	Occupation
Primary Care Physician:	Pharmacy Name and Location
Referring Physician	

Communication Preferences

Phone Numbers

Cell:	Marital Status _____
Home:	Preferred Language _____
Work:	Interpreter Needed: ☐ Yes ☐ No
Preferred Phone # ☐ Cell ☐ Home ☐ Work	Ethnicity: ☐ Non Hispanic ☐ Other _____ ☐ Hispanic ☐ Unknown
OK to leave voice mail regarding appointment, clinical, or financial information? ☐ Yes ☐ No	Race: ☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other ☐ Patient Declined

Emergency Contact

Name (Last, First, Middle):	Permission to Disclose Healthcare Information ☐ Yes ☐ No
	Regarding Appointments? ☐ Yes ☐ No
Relationship to Patient:	Regarding Clinical Information? ☐ Yes ☐ No
Phone # ☐ Cell ☐ Home ☐ Work	Regarding Financial Information? ☐ Yes ☐ No

Person Financially Responsible ☐ check here if self

Name (Last, First, Middle)	Relationship to Patient
Address	Home Phone
City State Zip	Cell Phone

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name	Insurance Name
Subscriber Name	Subscriber Name
Subscriber DOB	Subscriber DOB
Policy Number	Policy Number
Group Number	Group Number
Effective Date	Effective Date

Patient or Guardian Signature _____ **Date** _____

GVH GRAND VIEW HEALTH

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I, _____ (Print Name) request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third party payer, under the terms of the insurance policy with _____(Insurance Company) or benefit plan to be paid directly to Grand View Health for services and goods provided by Grand View Health.

- I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan for services and goods provided by Grand View Health.
- In event that I fail to make full payment or fail to comply with other payment arrangements made with Grand View Health's approval, I understand appropriate collection measure may be initiated.
- If my account is referred to an attorney or agency for collections of any unpaid balances for which I am responsible, I understand that I will also be responsible for all collection costs, including reasonable attorney's fees and court costs.
- My obligations to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
- That I am responsible to know and understand what services are covered under my insurance policy.

RELEASE OF INFORMATION

I authorize GVH and/or their agents:

- To release to my insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to process related health claims, receive payment or to obtain authorization for services, supplies and equipment in accordance with HIPAA standards..
- To request and to receive directly, on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against my insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
- To give medical or other information to any healthcare practitioner furnishing health care services to me or receive information from them in accordance with HIPAA standards.

STATEMENT OF ASSISTANCE

I agree:

- To assist GVH in collections that may be due or payable under my insurance policy or benefit plan for the service, supplies and equipment provided.
- To provide any additional information needed to process the claim for payment.
- That a photocopy or other reproduction of this document shall be considered as valid as the original.

By signing below I am certifying that the information on this form is correct and current:

_____ _____

Signature of Patient or Person Authorized to Consent for Patient | Date

_____ _____

Signature of Witness | Date

If the patient is unable to sign upon arrival, state the reason: _____

GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
215-453-4000
www.gvh.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Privacy Officer at Grand View Health, on this organization's website, or by requesting one at this organization's offices.

_____
Date

_____
Signature

_____
Print or Type Name

- As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____
Signature Relationship

GVH GRAND VIEW HEALTH

GVH GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
(215) 453-4850

MyGVH.org

Patient Portal Enrollment Form

Please complete the information below. A Grand View Health representative will set up your portal account and you will receive an email to the email address provided below with instructions to complete your enrollment within the next 2-3 business days.

I understand that patient information within the portal may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, Behavioral Health services/psychiatric care, or treatment for alcohol and/or drug abuse.

Should you like to access patient information for someone other than yourself, please fill out an Authorization for Proxy Access to GVH Patient Portal form.

Patient Name _____

Address _____City_____State_____ Zip Code _____

Date of birth (month/day/year) _____/_____/_____

Phone Number: _____

Medical Record # (if available) _____

Email address _____

Verify Email address _____

Signature _____ Date _____

FOR STAFF USE ONLY

Patient name as shown in EMR: _____

Medical Record # as shown in EMR: _____

DOB as shown in EMR: _____

ID Verified by: _____

Enrollment completed by: _____
(Print Name)

☐ Patient Identification
☐ Photo ID
☐ POA Provided
☐ Office
☐ Patient Registration
☐ Health Information Management

Please present completed Patient Portal Enrollment Form to the Health Information Management Department with photo ID.

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Your provider will use this information as a screening tool for cancers that run in families. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.

The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces, and nephews on both sides of the family.

Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers**?	☐ Y ☐ N	List them here:		

Your provider will use the following information to determine if you should consider carrier screening.

Do you plan to become pregnant in the next year?	☐ Y ☐ N	Do you have Ashkenazi Jewish ancestry?	☐ Y ☐ N

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient is appropriate for genetic testing ☐ Yes ☐ No

Patient offered genetic testing today ☐ Accepted ☐ Declined

Patient referred to High Risk Program ☐ Accepted ☐ Declined

If patient is appropriate and DECLINES genetic testing or referred, patient signature: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____