



**CARROLL COUNTY
GENERAL HEALTH DISTRICT**
Healthy People — Safe Communities

CONSENT FOR EXAMINATION, TREATMENT and PAYMENT

I request Carroll County Health Department to perform an examination and/or lab tests on me. I understand that all reasonable attempts will be made to contact me if any test result ordered by a Health Department physician is abnormal.

In consideration of the above-mentioned services rendered to me by the Carroll County Health Department, I hereby release and forever discharge the Carroll County Health Department and its Trustees, Board Officers, Employees, Clinic Physician and Nursing Staff from all claims, damages, actions and causes of action arising out of any injury or damages resulting from said service or any effect thereof presently known or unknown now and forever in the future.

Every client shall receive equal consideration and not be excluded from participation in or be denied the benefits of or otherwise be subjected to discrimination on the grounds of race, sex, national, origin, color or handicap.

I agree to accept responsibility for any additional and/or follow-up care that may not be available from the Carroll County Health Department. I give my permission to the employees of the Carroll County Health Department and others authorized by them to use information contained in my medical record for statistical purposes, and as required by law, with the understanding that confidentiality will be maintained. Client confidentiality will be upheld without notification to the parent or legal guardian as applicable. We cannot give out any information about you to anyone without your consent. **EXCEPTION: If you report any physical abuse, sexual abuse, or report feeling suicidal or homicidal, by law, we must find someone to help you.**

The goal of the Carroll County Health Department is to promote the health and well being of all that receive our services. There is no residency requirement to participate in the Carroll County Health Department Reproductive Health Clinic.

Fees for all services are expected on the date of service. For those who may have difficulty paying upon request may set up a payment plan with the billing office, this must be set up prior to the appointment and a payment must be made at the time of service. We accept Medicaid, Private insurance, cash or check and credit card (Fee of 3% or \$2.00 whichever is greater) for payment.

My signature verifies that all information provided to the Carroll County Health Department is truthful and accurate to the best of my knowledge. My signature is also agreement to provide payment of all charges at the time of service.

Parent or Client Signature _____ Date of Service _____

Client Name _____ SSN _____ Date of Birth _____

If you have the following insurances Aultcare, Cigna, Medical Mutual, Anthem BC/BS, Tricare, Aetna, Ohio Health Choice, Summa, Priority Health, United Health Care, Health America, Health Smart, Multiplan, Pai, The Health Plan of the Upper Ohio Valley Please fill out the following information so we can bill your insurance correctly and efficiently.

Name of Person who carries the Insurance if Different then client:
Relation to Client:
Date of Birth of Insurance Carrier:
Social Security Number of Insurance Carrier:

Office Use Only

Witness Signature _____ Date of Service _____

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Medical STD Form

Patient Name: _____ Date of Birth: _____ Date: _____

Are you pregnant? Yes No If yes, how far along are you? _____

Do you have drug allergies? Yes No
If yes, please list: _____

Did you receive treatment? Yes No
If yes, please complete the following:

Drug: _____ Frequency: _____ Start: _____

Dose: _____ End: _____

Answer the following:

Internet Partner Services Utilized Yes No If yes, _____

First social media site accessed:

- Facebook Adam4Adam
 Grindr GayBlackChat
 Craigslist Other: Please specify: _____

Second social media site accessed:

- Facebook Adam4Adam
 Grindr GayBlackChat
 Craigslist Other: Please specify: _____

Internet partner Services successful Yes No

Do you have sex with male? Yes No Do you have sex with females? Yes No

Have you been tested for HIV at his event? Yes No Refused to answer Did not ask Unknown

Have you had any Incidental antimicrobial treatment in the last 12 months? Yes No

If yes, please complete the following:

Drug: _____ Frequency: _____ Start: _____

Dose: _____ End: _____

Has your partner been tested? Yes No If yes, did they test positive? Yes No

Did they receive any treatment? Yes No

Name of Partner: _____

Address: _____

If no, please ask they get treated to stop the spread of disease



Health History

Name: _____ Date of Birth: _____ Age: _____

Are you Allergic to any medication/Herbs/Vitamins? _____

Are you Allergic to anything else: _____

Recent Changes in Family Medical History: _____

Have you in the past 12 months been: Hospitalized Yes No Surgery Yes No Major Illness Yes No

Current Birth Control Method: None Depo Nexplanon Oral Birth Control IUD Problems: Yes No

Do you desire a Different Method: Yes No When was the 1st day of your last period? _____

How many Sexual Partners in past 12 months? _____

How long have you been with your current partner? _____

Do you have any new problems or questions for us? _____

Do you currently smoke? Yes No How much do you smoke daily? _____

Do you drink alcohol? Yes No How many drinks do you have a day? _____ How often? _____

Do you use street drugs? Yes No What type? _____ How often? _____

Do you use prescription drugs/over the counter drugs to get high? Yes No How often? _____

Would you like any of the Following services while you are here today?

- STD Testing
- HIV Testing
- Hepatitis C

- HPV – Gardasil Vaccine
- Flu Shot

Almost Done! Turn Over the page!

Are you currently experiencing any of these symptoms?

Check All symptoms that apply to you:

GENERAL

- Chills
- Fever
- Sweats
- Dizziness/Fainting
- Headaches
- Change in sleep pattern
- Numbness/Pain
- Skin (rash/bruise/sores/mole change)
- Other

GASTROINTESTINAL

- Poor appetite
- Bloating
- Constipation
- Diarrhea
- Nausea/Vomiting
- Indigestion
- Excessive thirst
- Hemorrhoids
- Stomach Pain

CARDIOVASCULAR

- Chest pain
- Irregular heartbeat
- Varicose veins
- Shortness of breath

GENITO-URINARY

- Blood in urine
- Frequent urination
- Painful urination
- Lack of bladder control

Eyes, Ears, Nose and Throat

- Sinus problems
- Persistent cough
- Difficulty swallowing
- Nosebleeds
- Hoarseness

Reproductive

- Breast Lump
- Irregular bleeding
- Nipple discharge
- Vaginal discharge

Are you in a relationship (partner/family member/other) in which you have been physically hurt or threatened? Yes No
Explain _____

Do you ever feel afraid or threatened by your partner/family member/other? Yes No

Do you feelings of:

- Depressed Mood
- Lack of energy
- Feeling of guilt/worthlessness
- Trouble Sleeping
- Sleeping to Much
- Thoughts of Suicide

Have you ever been pressured or forced to have sex? Yes No

Have you ever had sex to get money or drugs? Yes No

Are you aware that the safest type of sex is no sex? Yes No

Is your family aware that you are a client at our clinic? Yes No

Is there anything else you would like us to know? _____



Reproductive Health Plan

Name: _____ Date of Birth: _____ Date: _____

What is your weekly Income: _____ How many people live in your home? _____
Are you a student? Yes No How many children are living with you currently? _____

What is the highest grade you have completed? _____

How do you plan to pay today? Medicaid Private Insurance Self Pay No Pay

Donation for services today? Yes No

When you first started having sex what did you use for birth control?
 None Condoms Depo Oral Birth Control IUD Other: _____

What form of birth control do you plan to use after your visit today?
 None Condoms Depo Oral Birth Control IUD Other: _____

How often do you use condoms? Not Applicable Always Never Sometimes

Do you want to become pregnant within the next year? Yes No

Do you want to have children one day? Yes No

If yes:

At what age you would like to have children? _____

How many children would you like? _____

How far apart would you like your children to be? _____

If no:

What will you do if you do become pregnant? _____

If you are currently pregnant:

Did you intend to become pregnant? Yes No

Were you using a form of contraception? Yes No

If Yes, Condoms Depo Oral Birth Control IUD

I currently have children Yes No How many children? _____ How many pregnancies have you had? _____

Almost Done! Turn Page Over!

Personal Habits

- If you are a current smoker are you thinking about quitting? Yes No If yes, How soon would you like to quit? _____
- Would you like services for quitting? Yes No _____
- Are you having sex with more than one partner/person? Yes No
- Do you sometimes go on unhealthy diets or overeat? Yes No
- Do you use street drugs or prescription drugs for fun? Yes No

Emotional Health

- When you feel sad do you bounce back quickly or feel sad for 2 weeks or more? Yes No
- How often do you feel nervous, anxious, or worried? _____
- How do you calm yourself down if you are angry? _____
- Is there anyone in your life who physically hurts you? Yes No
- Is there anyone in your life who often says hurtful or mean things? Yes No

Important Vaccinations

Check all vaccinations you have received:

- | | |
|---|---|
| <input type="checkbox"/> Tetanus/Tdap | <input type="checkbox"/> Varicella (chicken pox) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Measles, Mumps, Rubella |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Inactivated Polio Virus |
| <input type="checkbox"/> Gardasil (HPV) | <input type="checkbox"/> Pertussis (whooping cough) |

Family History

Check all of those which have happened in your immediate family:

- | | |
|--|--|
| <input type="checkbox"/> A baby born too soon or weighing less than 5 ½ pounds | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure in pregnancy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes in pregnancy | <input type="checkbox"/> Heart or Lung Disease |
| <input type="checkbox"/> Two or more miscarriages | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stillborn baby | |
| <input type="checkbox"/> Baby with a heart defect | |

Personal Goals:

- I will take a daily multivitamin or prenatal vitamin with folic acid.
- I will start exercising or exercise more often.
- I will **quit** smoking or **smoke less**.
- I will **increase** or **always** use condoms when having sex.
- I will **quit** or **decrease** the amount of alcohol or drugs I use.
- I will **increase, maintain** or **reduce** my weight.
- I will not get pregnant until I am ready by not having sex or by always using birth control.