

Name		Date of birth	
Preferred name/nickname		Social Security number	
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline to state	Race <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White (includes Middle Eastern) <input type="checkbox"/> Decline to state	Emergency contact name: Emergency contact phone number: Relationship to you:	
<i>Please choose the answers that are best for you. If none are right for you, please mark "decline to state".</i>			
Are you a veteran of the US Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you need an interpreter to communicate in English? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is your preferred language?	
How did you hear about us? <input type="checkbox"/> workshop, health fair, community event <input type="checkbox"/> relative/friend <input type="checkbox"/> another medical provider <input type="checkbox"/> postcard <input type="checkbox"/> condom ladies/Ladies <input type="checkbox"/> Night <input type="checkbox"/> walking by <input type="checkbox"/> web search			What is your yearly income? _____
			How many people does your income support, including you? _____
Which of these best describes your living situation? <input type="checkbox"/> Own a home <input type="checkbox"/> Rent home/apartment/room <input type="checkbox"/> Permanently live with relative/friend <input type="checkbox"/> Temporarily live with relative/friend, or living in a hotel/motel <input type="checkbox"/> Shelter <input type="checkbox"/> Street, camping, or vehicle			Do you work on a farm? <input type="checkbox"/> No <input type="checkbox"/> Yes, I work on a farm part of the year <input type="checkbox"/> Yes, I move around for farm work
Sexual orientation <input type="checkbox"/> lesbian or gay <input type="checkbox"/> straight <input type="checkbox"/> bisexual <input type="checkbox"/> don't know <input type="checkbox"/> rather not say <input type="checkbox"/> other:	Gender identity <input type="checkbox"/> woman/female <input type="checkbox"/> male/man <input type="checkbox"/> trans, FTM <input type="checkbox"/> trans, MTF <input type="checkbox"/> rather not say <input type="checkbox"/> other:	Pronoun <input type="checkbox"/> she/her <input type="checkbox"/> he/him <input type="checkbox"/> they/them <input type="checkbox"/> ze/zim <input type="checkbox"/> other:	Would you like to get text message reminders for your upcoming appointments, instead of phone calls? <input type="checkbox"/> yes number: _____ <input type="checkbox"/> no thanks Data and carrier charges may apply. We'll never text you medical information.

Electronic Privacy at Women's Community Clinic

Epic

Women's Community Clinic uses an electronic health record system called Epic. Records in Epic can be shared with other health care providers that use the same system, like Kaiser and UCSF. The information that can be shared includes your medications, your labs, and notes from your visits with your provider.

Why this can be helpful: Sharing this information can give you better care. If you go to an emergency room that uses Epic, they will be able to see your medical history. If you see a new provider who uses Epic, you will not need to transfer your records to them.

Why this might not be right for you: If you are coming to Women's Community Clinic because you have concerns about privacy, you should know that this information could be shared with other providers. For example, if you had Kaiser Insurance through your parents, your provider at Kaiser could see the birth control method that we prescribed for you.

We can lock your record so that your information is not visible to other health care providers through Epic. Please see our Notice of Privacy Practices for other ways we may use your health information.

- Please **lock** my record so that my information is not visible to other health care providers through Epic.
- Please keep my record **open** so that other providers who use Epic can see my information if they need to.

Other health care providers and facilities can only see your information if you are or have been their patient, and they have to follow state and federal privacy laws like we do.

Pharmacies

Most pharmacies now use big databases to track patients and prescriptions. Epic automatically checks your name, date of birth, and Social Security number against these databases. If it finds a match it will tell us what prescriptions you have gotten from other providers. This is very helpful to make sure that we do not give you new prescriptions that will interact badly with your existing ones. We want you to know that it can work both ways—other providers may be able to see the prescriptions we give you. We cannot turn off this feature of data-matching to pharmacy databases.

California Immunization Registry

Women's Community Clinic has to report all immunizations (vaccines) and tuberculosis tests to the California Immunization Registry. This is very helpful to make sure that you get all your immunizations, and don't get immunizations that you don't need. However, if you are here for privacy reasons, we want you to know that your school or family provider could see that you got an immunization at our clinic.

If we give you a vaccination, we have to report your vaccination to the state registry, but we can tell the registry never to share your immunization information with other providers. If you want us to do that, we will need you to sign a special consent form.

- Please ask the Immunization Registry to **not** share my immunization information with other providers.
- Please **allow** the Immunization Registry to share my immunization information with other providers.

Sign: _____ Print Name: _____ Date: _____



Name: _____

DOB: _____

Allergies to medications, latex, or shellfish: _____

Allergic reaction (like hives, trouble breathing, vomiting): _____

Current Medications: _____

Your Past Medical History

- No Yes anxiety No Yes clotting disorder or blood clots in legs or lungs
No Yes depression No Yes hypertension (high blood pressure)
No Yes other mental health concerns: No Yes heart problems or high cholesterol
No Yes asthma or lung disease No Yes incontinence
No Yes cancer No Yes stroke
No Yes HIV No Yes migraine headaches
No Yes breast problems (masses, lumps, surgeries)

Have you ever had any sexually transmitted infections? (STI or STD)? If yes, when?

- Herpes (oral/genital) Warts
Chlamydia Tested positive for HPV
Gonorrhea Syphilis

When was your last pap smear? _____

Have you ever had an abnormal pap smear? No Yes If yes, when? _____

Do you have any other medical conditions? _____

Have you had any surgeries? _____

Depression screening -- In the past 2 weeks:

- Have you felt down, depressed or hopeless? No Yes
- Have you had little interest or pleasure in doing things? (In other words, are you not enjoying things you normally enjoy?)
No Yes

Your Family History

Were you adopted? No Yes

Table with 2 columns: Illness type and description. Rows include Breast cancer, Ovarian cancer, Heart attack, Diabetes, High Cholesterol, Hypertension, Kidney Disease, Stroke, and Other major illnesses.

Number of past: pregnancies: births: miscarriages: abortions: living children: _____

Any problems with pregnancies? No Yes _____

Did you receive basic childhood vaccines? No Yes

When was your most recent: Flu Shot Tetanus Shot (Tdap or Td) _____

Hep A vaccination (series of 2 shots) Hep B vaccination (series of 3 shots) _____

TB Test HPV Vaccine (series of 3 shots) _____