**Name**

**Date of birth**

**Preferred name/nickname**

**Social Security number**

**Ethnicity**
□ Hispanic
□ Non-Hispanic
□ Decline to state

*Please choose the answers that are best for you. If none are right for you, please mark "decline to state".*

**Race**
□ American Indian
□ Alaskan Native
□ Asian
□ Black or African American
□ Native Hawaiian
□ Pacific Islander
□ White (includes Middle Eastern)
□ Decline to state

**Emergency contact name:**

**Emergency contact phone number:**

**Relationship to you:**

**Are you a veteran of the US Armed Forces?**
□ Yes □ No

**Do you have a physical or mental disability?**
□ Yes □ No

**Do you need an interpreter to communicate in English?**
□ Yes □ No

**What is your preferred language?**

**How did you hear about us?**
□ workshop, health fair, community event
□ relative/friend
□ another medical provider
□ postcard
□ condom ladies/Ladies Night
□ walking by
□ web search

**What is your yearly income?**
_____

**How many people does your income support, including you?**
_____

**Which of these best describes your living situation?**
□ Own a home
□ Rent home/apartment/room
□ Permanently live with relative/friend
□ Temporarily live with relative/friend, or living in a hotel/motel
□ Shelter
□ Street, camping, or vehicle

**Do you work on a farm?**
□ No
□ Yes, I work on a farm part of the year
□ Yes, I move around for farm work

**Sexual orientation**
□ lesbian or gay
□ straight
□ bisexual
□ don't know
□ rather not say
□ other:

**Gender identity**
□ woman/female
□ male/man
□ trans, FTM
□ trans, MTF
□ rather not say
□ other:

**Pronoun**
□ she/her
□ he/him
□ they/them
□ ze/zim
□ other:

**Would you like to get text message reminders for your upcoming appointments, instead of phone calls?**
□ yes
number: _____
□ 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**: _____

womens community clinic

# Health History Form

**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 depression
No Yes other mental health concerns: _____
No Yes asthma or lung disease
No Yes cancer
No Yes HIV
No Yes clotting disorder or blood clots in legs or lungs
No Yes hypertension (high blood pressure)
No Yes heart problems or high cholesterol
No Yes incontinence
No Yes stroke
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

| | Tell us which family members have had the following – Only parents, grandparents, siblings, and children (**please state maternal or paternal**) |
|---|---|
| Breast cancer (including aunts) | |
| Ovarian cancer (including aunts) | |
| Other cancer | |
| Heart attack/heart disease | |
| Diabetes | |
| High Cholesterol | |
| Hypertension (high blood pressure) | |
| Kidney Disease | |
| Stroke or blood clot in vein | |
| 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)_____