PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Southern Ute Tribal Health Department to release my records and discuss any information requested to the following individuals.

1. _____ **Relation to Patient:** _____
2. _____ **Relation to Patient:** _____
3. _____ **Relation to Patient:** _____
4. _____ **Relation to Patient:** _____

Authorization Regarding Messages(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medicaltreatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature

HEALTH QUESTIONNAIRE

Confidential Data

Name:	Date of Birth:	Date:
Reason for Visit and Symptoms:		

Other Medical Personnel Involved in Your Care

Name:	Phone number:	Reason:

Allergies/Intolerances

Allergen Name	Reaction	Start Date

Medication - List **all** prescription medications you currently take.

Medication	Start Date	Strength	How Often	Reason

Supplements - List **all** vitamins, hormones, alternative remedies or over the counter medications you use.

Medication	Start Date	Strength	How Often	Reason

Preventative Care - List date of last test or screening

Test	Date of last test or screening
Colonoscopy:	
Dental examination:	
DEXA (bone density):	
Eye Exam:	

Male Patients	Date of last test	Please check below symptoms if applicable
PSA laboratory test:		□ Diminished libido □ Difficulty obtaining or maintaining an erection
Rectal/prostate exam:		□ Urinary: decreased flow or delayed flow
Testicular exam:		□ Urethral discharge

<table>
<tr><td colspan="3">Name: Date of Birth: Date:</td></tr>
<tr><td colspan="2">Female Patients Date of Last Exam/Test</td><td>Menstrual History</td></tr>
<tr><td colspan="2">Breast exam:</td><td>Age of onset:</td></tr>
<tr><td colspan="2">Mammogram:</td><td>Date of last period:</td></tr>
<tr><td colspan="2">Pap smear:</td><td>Length of cycle:
□ regular □ irregular</td></tr>
<tr><td colspan="2">Rectal examination:</td><td>Days of flow:</td></tr>
<tr><td colspan="2">SEXUAL HISTORY</td><td>Flow Description:
□ Heavy □ Moderate □ Light
□ Pain □ Cramps □ Clots</td></tr>
<tr><td colspan="2">□ Pain during or after intercourse
□ Bleeding after intercourse
□ Diminished libido
□ Infertility</td><td>□ Menopause Symptoms (flushing, moodiness, changes in cycle, other)</td></tr>
<tr><td>No. of pregnancies</td><td></td><td rowspan="4">Age of menopausal onset</td></tr>
<tr><td>Live births</td><td></td></tr>
<tr><td>Miscarriages</td><td></td></tr>
<tr><td>Abortions</td><td></td></tr>
<tr><td colspan="3">Birth control method:</td></tr>
</table>

Name: Date of Birth: Date:

Health History

Are you being treated for, or have you had any of the following health conditions? Please check if applicable. Additional space is provided below for details or other health conditions not listed.

□ Allergies	□ Defibrillator	□ High blood pressure	□ Peripheral vascular disease
□ Alcohol Problems	□ Dementia	□ HIV/AIDS	□ Pleurisy
□ Anemia	□ Depression	□ Hyperthyroidism	□ Pneumonia
□ Aneurysm	□ Diabetes	□ Hypothyroidism	□ Prostate problems
□ Anxiety	□ Diarrhea	□ Irritable bowel	□ Seizure disorder
□ Arthritis	□ Diverticulosis or diverticulitis	□ Kidney disease	□ Sexually transmitted disease(s)
□ Asthma	□ Eating disorder	□ Kidney failure	□ Sleep apnea
□ Atrial fibrillation	□ Emphysema	□ Kidney stones	□ Stents
□ Bleeding problems	□ Fertility issues	□ Low back pain	□ Stroke
□ Blood clots	□ GERD	□ Lupus (SLE)	□ TIA
□ Blood transfusion	□ Glaucoma	□ Mental Illness/mood disorder	□ Tremors
□ Bronchitis	□ Goiter	□ MSRA infections	□ Tuberculosis
□ Cancer	□ Gout	□ Narcolepsy	□ Urinary
Type:	□ Headaches	□ Neuropathy	□ Valvular disease
□ CHF	□ Heart attack	□ Nervous System disease	□ Varicose veins
□ Crohn's disease	□ Heart disease	□ Obesity	□ Weight problems
□ Colitis	□ Heart Failure	□ Pacemaker	
□ Constipation	□ Hemorrhoids	□ Palpitations	
□ COPD	□ Hepatitis	□ Peptic ulcer(s)	

List additional information and other health conditions not listed above: _____

_____

_____

_____

HEALTH QUESTIONNAIRE
Confidential Data

Name:	Date of Birth:	Date:

Past Hospitalizations/Procedures/Surgeries

List surgical procedures, reasons for hospitalizations and the year.

Type	Approximate Date	Type	Approximate Date

Immunizations: List date of last injection and if record is attached.

Injection	Date	Record Attached?	Injection	Date	Record Attached?
Gardasil		□ Yes □ No	Pneumonia		□ Yes □ No
Hepatitis A		□ Yes □ No	Polio		□ Yes □ No
Hepatitis B		□ Yes □ No	Tetanus		□ Yes □ No
Influenza		□ Yes □ No	T-dap		□ Yes □ No
MMR		□ Yes □ No	Typhoid		□ Yes □ No
Meningitis		□ Yes □ No	Zostavax		□ Yes □ No

Social, Safety, Cultural, Communication History

Smoking Status □ Current daily smoker □ Current someday smoker □ Former smoker
□ Never smoker
If current or quit within 12 months, □ Cigarettes □Cigars □ Pipe □ Smokeless
If current or quit within 12 months, Smoking Cessation Counseling □ Yes □ No

Preferred language: Ethnicity □Hispanic/Latino □ Not Hispanic/Latino

Race: □ White □ African American □ American Indian/Alaskan □Asian □Hawaiian/Pacific Islander □ Other

Relationship status: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Other

Alcohol? □ Yes □ No □ Rarely Amount_____ drinks per day/week/month
Caffeine? □ Yes □ No Amount_____ cups per day/week/month

Do you/or have you had a problem with drug use □ Yes □ No If yes, list type

Do you exercise? □ Yes □ No If yes, list type frequency

Do you have children? □ Yes □ No If yes, how many? ___
Seatbelt usage? □ Yes □ No Percent of time worn:

Have you been hit or threatened in the past year? □ Yes □ No

Are there cultural or religious beliefs that need to be considered in your care? □ Yes □ No
If yes, explain:

Potential barrier to learning: □ none □ inability to understand English
□ Language (if other than English) □ blind □ poor vision □ deaf □ decreased hearing
□ unable to talk □ unable to read □ memory loss

Learns best by: □ reading □ verbal instruction □ practicing □ talking □ watching □ other

Do you have a:
Durable Power of Attorney? □Yes □ No If yes, list person(s):_____
Healthcare representative? □Yes □ No If yes, list person(s): _____
Living Will? □Yes □ No If yes, list person(s): _____
DNR Do Not Resuscitate? □ Yes □ No
Would you like information on any of the above? □ Yes □ No

HEALTH QUESTIONNAIRE
Confidential Data

Name:	Date of Birth:	Date:

Family History Mark the appropriate box	**Alive and well**	**Deceased**	**Age at death**	**Cause of death**	**High blood pressure**	**Heart disease**	**High cholesterol**	**Diabetes**	**Cancer**	**Asthma**	**COPD**	**Tuberculosis**	**Arthritis**	**Kidney disease**	**Glaucoma**	**Stroke**	**Migraine**	**Mental illness**	**Alcoholism**	**Anemia**	**Gout**	**Seizures**
Father																						
Paternal Grandfather																						
Paternal Grandmother																						
Mother																						
Paternal Grandfather																						
Paternal Grandmother																						
Sibling 1																						
Sibling 2																						
Sibling 3																						
Sibling 4																						
Spouse																						

Additional Comments or Information:

_____

_____

_____

Person completing form Signature Date