11555 Central Parkway, Suite #402, Jacksonville, FL 32224

Phone: (904) 747-3800 Fax: (904) 747-3733

Kia M. Mitchell, MD **Thanh Nguyen, MD**

Myeisha Carter, MSN, APRN **Brandy Fulton, APRN**

Date: ________________

Patient's Full Legal Name ____

Nickname or name patient goes by ____

Social Security #______________________DOB________________Age ________

Address____

City, State, Zip ____

Home Phone #______________________Cell Phone # ______________________

Email Address ____

Driver's License # ____

Gender: Male Female Marital Status: Single Engaged Married Divorced

Spouse/ Other Name/ Age: ____

Name(s)/ Age(s) of children ____

Employer______________________Occupation ______________________

Business Address ____

City, State, Zip______________________Work Phone # ______________________

Who may we thank for referring you to our office? ______________________

In case of emergency,
who should be notified?______________________Relationship to patient ______________________

Insurance Information (Primary coverage)

Name of Person Holding Policy____

Relationship to Patient____

Insurance Co. Name______________________ Policy #______________________

Address______________________ Group #______________________

Address con't______________________ Phone #______________________

City, State, Zip______________________ Effective date coverage began ______________

Insurance Information (Secondary - if applicable)

Name of Person Holding Policy____

Relationship to Patient ____

Insurance Co. Name______________________ Policy #______________________

Address______________________ Group #______________________

Address con’t______________________ Phone #______________________

City, State, ZIP______________________ Effective date coverage began______________

Insurance Assignment and Release

I, the undersigned, certify that I have insurance coverage with______________________

(Name of Insurance Company)

and assign directly to FAMILIES FIRST MEDICAL GROUP insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature____ Date ______________

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EMERGENCY CARE/CONSENT FOR TREATMENT

Patient's Name____Date of Birth ________________

I hereby give permission to all of the providers of FAMILIES FIRST MEDICAL GROUP to direct any emergency medical treatment needed to me.

It is understood that they will make every effort to contact my next of kin or emergency contact in case of a medical emergency. It is further understood that if they are unable the emergency contact, I give them this permission with my full consent.

If hospitalization is necessary, I direct the providers of FAMILIES FIRST MEDICAL GROUP to arrange admission for me. I will be financially responsible for all hospital expenses.

Listed below is my emergency contact/next of kin to contact in case of emergency.

Please list below:

Name:	Relationship

Signature of patient: ____Date ______________

Witness:____(FFMG Staff)

Medical and Family History Form

Date of Last Annual Wellness Exam: ____________

Most important concerns for this visit:

1.____

2.____

ALLERGIES to Medication(s): [ ] Yes (detail below) [ ] No Known Drug Allergies

Medication:______________________________Reaction: ______________________________

Medication:______________________________Reaction: ______________________________

Medication:______________________________Reaction: ______________________________

Other Allergies (please list):____

MEDICATIONS: Please list all prescription medications, over-the-counter medications, vitamins, and other supplements you are currently taking:

	Medication Name	**Dose (mg)**	**Type (tablet, cream, IV)**	**How Often?**
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please indicate if you have had any of the following screening tests, and the most recent date:

Colonoscopy:___________DEXA (bone density):___________Women: Pap:_____________Mammogram: ____________

Adult immunizations: It is very important for us to have the dates of your most recent immunizations. Please check with your previous provider for dates.

Tetanus [ ] Yes [ ] No Date:__________ Was pertussis included (Tdap)? [ ] Yes [ ] No

Pneumonia [ ] Yes [ ] No Date:___________Zostavax [ ] Yes [ ] No Date: ___________

Hepatitis B [ ] Yes [ ] No Dates (3 shots): ____

HPV [ ] Yes [ ] No Dates (3 shots): ____

CURRENT HEALTH SYMPTOMS
Please complete all questions:

1. Have you had a recent weight gain or loss that worries you? [ ] Yes [ ] No
2. Have you had any unexplained fevers or night sweats? [ ] Yes [ ]No
3. Do you have sinus or nasal allergy symptoms that affect your quality of life? [ ] Yes [ ] No
4. Do you have any vision or hearing problems that are bothersome? [ ] Yes [ ] No
5. Are you experiencing chest pains or irregular beats that worry you? [ ] Yes [ ] No
6. Do you have unusual shortness of breath or a persistent cough? [ ] Yes [ ] No
7. Do you have leg swelling that is recurrent or bothersome? [ ] Yes [ ] No
8. Do you experience wheezing when you breathe? [ ] Yes [ ] No
9. Do you have sleep problems that interferes with quality of life? [ ] Yes [ ] No
10. Have you been told that you snore and stop breathing during sleep? [ ] Yes [ ] No
11. Do you have constipation, diarrhea, stomach pain or other problems with digestion that interfere with your quality of life? [ ] Yes [ ] No
12. Have your bowel movement patterns changed in recent months? [ ] Yes [ ] No
13. Do you have problems with urination that affects quality of life? [ ] Yes [ ] No
14. Do you have problems with sexual function that affects quality of life? [ ] Yes [ ] No
15. Do you have joint or back problems that affect your quality of life? [ ] Yes [ ] No
16. Do you have leg pain, numbness or weakness that limits how fast or far you can walk? [ ] Yes [ ] No
17. Do you have headaches that affect your ability to function? [ ] Yes [ ] No
18. Have you had an unexpected fall with injury in the past year? [ ] Yes [ ] No
19. Do you have poor balance or fear of falling? [ ] Yes [ ] No
20. Do you have little pleasure in doing things? [ ] Yes [ ] No
21. Do you feel down, depressed, or hopeless? [ ] Yes [ ] No
22. Are you concerned about anxiety or stress in your life? [ ] Yes [ ] No
23. Are you concerned about your memory? [ ] Yes [ ]No
24. Have you noticed unusual bruising or bleeding? [ ] Yes [ ] No
25. Do you have unusual skin lesions that concern you? [ ] Yes [ ] No

Comments: ____

____

* Note: Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or an additional appointment to follow up on these problems.

*Patient initials _____________

CONSENT FOR MEDICAL TREATMENT

Page 1 of 2

1. CONSENT FOR HEALTH CARE SERVICES. I authorize physician(s), therapists(s), their assistants and/ or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at FAMILIES FIRST MEDICAL GROUP. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that Families First Medical Clinic may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered by the practice.

2. Families First Medical Group practitioners. I understand that I may receive services from professionals who provide care to me who are not employees or agents of Families First Medical Clinic. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from Families First Medical Group. I understand that, in some cases, these non-FAMILIES FIRST MEDICAL GROUP Clinic professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

3.MEDICARE and/or MEDICAID CERTIFICATION. I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4. FINANCIAL AGREEMENT. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide to the practice or any entity to which the practice assigns my account, as well as the use of technology including auto-dialing and/or prerecorded messages in contacting me.

All official FAMILIES FIRST MEDICAL GROUP policies are maintained electronically and are subject to change. No printed policy should be taken as the official policy except to the extent it is consistent with the FAMILIES FIRST MEDICAL GROUP policy that is electronically maintained.

5. PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to verify that all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6. ASSIGNMENT FOR DIRECT PAYMENT. I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

7. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that FAMILIES FIRST MEDICAL GROUP has offered me a copy of its Notice of Privacy Practices.

By checking one of the boxes below, I acknowledge:

- ☐ I have been offered or accepted a copy of the Notice of Privacy Practices
- ☐ I declined a copy of the Notice of Privacy Practices

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

____

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

____

ADDRESS OF PATIENT

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CLASSIFICATION OF ETHNICITY & RACE

Providing you with the very best care is our highest consideration. In order do that, it will help us to know a little bit about you.

While most diseases cross all ethnic/racial and gender boundaries, there are certain disease processes that are more likely to occur in a certain race or gender. In fact, some people may have different symptoms, or respond differently to treatments, because of these factors.

For that reason, we would like for you to share some information with us about your race/ethnicity. Sharing this information is entirely optional, but we believe it will assist our physicians and other care-givers in serving you best. It will not be used as a basis to deny or otherwise restrict the health care services you receive. Please consider the information below. Thank you.

Ethnicity

Do you consider yourself to be Hispanic or Latino according to the definition below?

(Choose only one)

- ☐ **Yes, I am Hispanic or Latino---**A person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race

- ☐ **No, I am not Hispanic or Latino**

Race

What race do you consider yourself to be?

- ☐ **American Indian or Alaska Native---**A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment

- ☐ **Asian---**A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

- ☐ **Black or African American---**A person having origins in any of the black racial groups of Africa.

- ☐ **Native Hawaiian or other Pacific Islander---**A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

- ☐ **White---**A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

- ☐ **Refuse to provide information---** I do not wish to provide some or all of the above information

- ☐ **More Than One Race** Please list:____

11555 Central Parkway, Suite #402, Jacksonville, FL 32224

FINANCIAL POLICY

Your understanding of our FINANCIAL POLICY is important to us. Please let us know if have any questions about our fees, financial policy or your responsibilities.

* CO-PAY, CO-INSURANCE, DEDUCTIBLES AND BALANCES ARE DUE AT THE TIME OF SERVICE

* WE ACCEPT CASH, VISA, MASTERCARD & DISCOVER

* NO SHOW FEE: 24-hour notice for cancellation must be given or there will be a $50.00 no show fee added to your account.

* BILLING
FAMILIES FIRST MEDICAL GROUP does not bill or extend credit. You are required to pay your co- pay, deductible, or any balance due at the time of service. We cannot hold checks. If you have an emergency situation or an issue that will prevent you from paying for your service, please contact our billing department in advance and they will discuss arrangements with you.

* INSURANCE
If we accept your insurance, you are responsible for any deductibles, co-insurance or co-pays at the time of service. IF YOUR INSURANCE CARRIER CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY US WHEN CHECKING IN. IF YOU FAIL TO DO SO, YOU MAY BECOME RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT.
Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company. You are responsible for the timely payment of your account.

* I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered, not covered by insurance. I have read all of the information above and understand it to the best of my knowledge. I will notify you of any and all future changes.

Signature of Patient____Date___________

PRIVACY POLICY

INTRODUCTION

FAMILIES FIRST MEDICAL GROUP is committed to protecting the privacy of our patients. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), FAMILIES FIRST MEDICAL GROUP has created a Privacy Policy. The purpose of this notification is to familiarize you with the existence of our policy, as well as give you an overview of its contents. The full written policy is available to you on request.

HIGHLIGHTS

Your Rights: You have a right to inspect and copy your protected health information. You have a right to request a restriction of your protected health information. You have the right to have your physician amend your health information. You have a right to receive an accounting of disclosures of your protected health information.

FAMILIES FIRST MEDICAL GROUP will use your private information in a variety of ways to facilitate your care. Some of these uses require your written consent and some do not. Private information (termed Protected Health Information or PHI in HIPPA), includes anything which individually might identify you (Name, SSN, diagnoses, etc.)

FAMILIES FIRST MEDICAL GROUP Clinic may use your PHI without written consent to communicate with emergency rooms, hospitals, specialists, lab and x-ray facilities, and other facilities involved in the current treatment of the patient. In addition, FAMILIES FIRST MEDICAL GROUP will routinely use PHI in the submission of billing to insurance companies. Also, any release required by law (mandatory notification of contagious disease to the health department, issues involving abuse or neglect, adverse drug and treatment reports to the FDA, issues involving criminal activity to law enforcement, or other releases required by law) may take place.

FAMILIES FIRST MEDICAL GROUP requires your written consent to release PHI to parties other than those listed above. This includes release to relatives other than immediate caregivers, to attorneys, to employers, to life insurance or disability insurance carriers, to research projects, or any others not listed previously.

FAMILIES FIRST MEDICAL GROUP does have business relationships with some companies who might periodically have access to your PHI. These include our attorneys, practice management consultants, computer system consultants and others. The purpose of these situations is for these entities to advise us, internally, on our practice operations. Kids & Families Medical Clinic maintains a contractual agreement with these entities which restricts their use of private information to their business relationship with us.

FAMILIES FIRST MEDICAL GROUP does increasingly use computer systems to transmit private information. This is largely to transmit claim and referral information with insurers and to exchange private information with other health care facilities. HIPPA mandates the secure electronic transmission of private information and we are in compliance with those requirements.

FAMILIES FIRST MEDICAL GROUP does use PHI during the day to day operations of the office. While certain uses of PHI (such as calling you by name in the waiting room) are acceptable, others (such as a person overhearing a telephone call regarding your case) are not. We are committed to preventing inadvertent disclosures. Your feedback about how we are doing in this or any other area is strongly encouraged.

Signed by Patient / Guardian:____Date:____________________

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Phone: (904) 747-3800 Fax: (904) 747-3733

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Patient Name______________________________________Patient SS#_____________________DOB____________________

Patient's Address____

I hereby authorize FAMILIES FIRST MEDICAL GROUP **to (please check one of the following):**

☐ **Obtain copies of my medical record (s) from:** ☐ **Release copies of my medical record (s) to**:

Name____

Address ____

Phone Number______________________________________Fax Number ____

Information as identified below is to be released:*(check all that apply)*

☐ **All Medical Records ***	☐ Emergency Room Report	☐ Mental/Behavioral Health Notes
☐ Progress Sheets/Clinic Notes	☐ Cardiac Rehab	☐ X-ray Reports
☐ Doctors Orders	☐ Operative Report	☐ Pulmonary Rehab
☐ Lab/Pathology Report	☐ Occupational Health	☐ Immunization Record
☐ PT/OT/ST	☐ Psychological Report	☐ History & Physical
☐ Discharge Summary	☐ Chemical Dependency	☐ Other______________________________

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable diseases (*if any such information exists),* may be released unless otherwise specified above.

*This information is needed for the following purpose(s):____

HIPAA Privacy Rule. I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

This authorization will automatically expire ninety (90) days following the date of signature.

I acknowledge that I have read and understand this authorization and its content.

Signature of Patient____Date ________________________

Signature of Parent or Legal Guardian____Date ________________________

Prohibition of Disclosure: Federal Law (42 CFR Part 2) and HIPAA 1996 prohibit further disclosure of this information except with written consent from the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Witness____(Staff Name) Date _______________________

Past Medical History:

Please review the list below and check any conditions you have had now or in the past.

- ☐ Abnormal Pap Smear
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer (What kind)
- ☐ Chronic Bronchitis
- ☐ Crohn's Disease or IBS
- ☐ Colon Polyps
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Frequent UTI's
- ☐ Freq Sinus Infections
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Condition (specify)
- ☐ Hepatitis (specify A, B, C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Melanoma or Skin Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Positive TB Skin Test
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Reflux (heartburn)
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sexually Trans. Disease
- ☐ (specify)
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Warts

Other medical problem(s) not on this list:____

Please check or list any **SURGERIES** you have had:

Type of surgery:	**Year**	**Type of surgery:**	**Year**
☐ Appendectomy	__________	☐ Hysterectomy	__________
☐ Arthroscopy (joint)	__________	☐ Knee or Hip Replacement	__________
☐ Back or Neck Surgery	__________	☐ Mastectomy or Lumpectomy	__________
☐ Cataract Surgery	__________	☐ Mastectomy/Lumpectomy	__________
☐ Cesarean Section	__________	☐ Polyp Removal (colon)	__________
☐ Gallbladder Removal	__________	☐ Tonsillectomy/Adenoidectomy	__________
☐ Heart Surgery (specify)	__________	☐ Tubal Ligation or Vasectomy	__________
☐ Hemorrhoids	__________	☐ Plastic Surgery (specify)	__________
☐ Hernia	__________	☐ Other (specify)	__________

Please list all previous **HOSPITALIZATIONS**:

Reason for hospitalization:	**Date**
____	__________
____	__________
____	__________
____	__________

For Women:

Last menstrual period	______________
Last pap smear	______________
Last mammogram	______________
Last bone density	______________
Age of first period	______________
# of days in cycle	______________
# of days in flow	______________
Are you menopausal	Y N
Age at onset of menopause	______________
# of pregnancies	______________
# of live births	______________
# of miscarriages	______________
# of abortions	______________
# of living children	______________

Family Health History:
Have any of your family members had any of the following health problems?

Condition:	**Family Member:**	**Condition:**	**Family Member:**
☐ Heart Disease/attack	______________	☐ Osteoporosis	______________
☐ Stroke	______________	☐ Migraines	______________
☐ Diabetes	______________	☐ Breast Cancer	______________
☐ High Blood Pressure	______________	☐ Colon Cancer	______________
☐ High Cholesterol	______________	☐ Prostate Cancer	______________
☐ Thyroid Disease	______________	☐ Lung Cancer	______________
☐ Depression	______________	☐ Ovarian Cancer	______________
☐ Other Mental Illness	______________	☐ Uterine Cancer	______________
☐ Alcoholism	______________	☐ Skin Cancer	______________
☐ Asthma	______________	☐ Other Cancer	______________

Any other illness in the family not listed? ____

Mother's Health Condition(s): ____

Living? Y/N If no, age at death__________

Father's Health Condition(s): ____

Living? Y/N If no, age at death__________

Sibling's Health Condition(s): ____

Other: ____

Health Habits:

1. Do you smoke currently? Yes No

    If yes, how much? # of cigarettes per day________# of years smoking ________

    If no, did you smoke in the past? Yes No How many years?______How much? # of packs per day ________

    Are you exposed to smoke? Yes No

    Any other tobacco use? Yes No Type: Cigars Chewing Tobacco Snuff Other

2. Do you drink caffeine? Yes No If so, how much?

3. Do you drink alcohol? Yes No What kind? Beer Wine Liquor Other:______________________

    If so, how many times per week?___________month?___________year? ________________

    Have you ever had a problem with alcohol in the past? (legal or social) Yes No

4. Have you ever used street drugs? Yes No

    Which ones? Marijuana IV drugs Amphetamines Cocaine Heroin Downers Inhalants

    Other ___________________________

    Are you still using? Yes No Which ones? ____

5. Are you sexually active (in the last year)? Yes No

    If yes, circle all that apply: 1 partner multiple partners Male partner(s) Female partner(s)

    Which birth control do you or your partner use? None Condoms Pill Vasectomy/tubal

    Other_______________________________________

6. Do you exercise? Yes No If so, what type and how often? ____

7. Do you eat out at restaurants weekly? Yes No Times per week ____________

8. How many servings of fruits and vegetables do you get per day? 0 1 2 3 4 5 >5

9. Do you take a calcium supplement? Yes No Number of dairy servings per day:________(e.g. milk, cheese)

10. Do you wear a seatbelt while in a vehicle? Yes No

11. Do you have a living will (do not resuscitate, medical power of attorney)? Yes No

    If no, would you like information? Yes No

12. Is there concern for your safety (emotional, physical, or sexual abuse)? Yes No

13. Do you feel safe at home? Yes No