Welcome to Fidalgo Medical Associates!

In order to prepare a current and accurate medical record prior to your visit, ***we request you please complete the enclosed forms and use the enclosed envelope to return the Health History Questionnaire 2 weeks prior to your appointment. Should we not receive your Health History Questionnaire prior to your appointment, your appointment will need to be rescheduled.***

On the day of your appointment, we require that you bring with you a photo ID, your insurance card(s), and all of your medications, including over-the-counter. Also, we will be taking a picture for your chart.

As you begin your care with us, we ask for your assistance in helping us keep down the costs of health care as we continue to meet the health needs of our community. Should you need to cancel your appointment you must provide at least **24-hour notice. Cancellations with less than 24-hour notice are considered a NO SHOW appointment.** We do understand that emergencies can occur, and are willing to work with you in these instances. We ask for prompt and consistent attendance at every appointment or you may be dismissed from the clinic.

Fidalgo Medical Associates is located at 1213 24th Street, Suite 100 in Island Medical Center building (see parking map), located within Island Hospital. Office hours are Monday through Friday from 8:00 AM until 5:00 PM. Our phone number is 360-293-3101 and our fax number is 360-293-3839.

Should you have any questions, concerns, or needs, please feel free to contact Fidalgo Medical Associates for assistance. Thank-you for being the most important part of Island Hospital.

Appointment Information

Your appointment will be with _____ on

_____

Please arrive at: _____

We look forward to meeting you,

Barbara Schmidt, Clinic Manager
Fidalgo Medical Associates
Phone: 360-293-3101
Fax: 360-293-3839

The Island Hospital Promise ~ *'Your best healthcare experience begins at Island Hospital. We always place your emotional and medical needs first and foremost'.*

ISLAND HOSPITAL

PATIENT INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Race	Religion	E-mail Address
Daytime Phone	Marital Status	DOB	Social Security #	Gender
Mother's Name (If patient is a minor)	Father's Name (If patient is a minor)		

GUARANTOR	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Relationship to Patient	DOB	Social Security #	Gender
Employer			
Employer's Address	City	State	Zip
Employer's Telephone Ext.	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown		

PATIENT EMPLOYMENT	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown
Occupation	Employer
Address	City State Zip
Employer's Telephone Ext.	Employer's Telephone Ext.

PRIMARY INSURANCE	Primary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

SECONDARY INSURANCE	Secondary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

⇨ SEE BACK SIDE

NEXT OF KIN INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

PERSON TO NOTIFY	Last Name	First Name	Middle Initial
Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

MEDICAL CONSENT

I consent to all medical and surgical treatment, laboratory, diagnostic imaging and other medical procedures performed and prescribed by the health care provider during clinic visits.

_____ _____

Signature *Date/Time*

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

_____ _____

Signature *Date/Time*

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

_____ _____

Signature *Date/Time*

MEDICARE PATIENTS ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE TO PROVIDER & PATIENTS

Name of beneficiary: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished to me at Island Hospital Family Care Clinics. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature *Date/Time*

ISLAND HOSPITAL

PATIENT RIGHTS

References: Washington State Law (WAC 246 320-141), Medicare's Conditions of Participation for Hospitals and DNV GL (NIAHO) Accreditation Requirements.

You have the right to:

- Be treated and cared for with dignity and respect without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.
- Receive information in a way that you can understand.
- Be informed of your rights before care is provided or discontinued whenever possible.
- Have family or your representative and your physician be told of your admission.
- Personal privacy during personal hygiene activities, medical/nursing treatments and when requested as appropriate. This also includes protecting your personal information from release or disclosure without your prior consent
- Provision of care in a physically and emotionally safe setting and access to protective services when necessary for your personal safety and be free from all forms of abuse, neglect, or harassment
- Participate in the development of your pain management plan and receive effective pain management.
- Be involved and informed in all aspects of your care and including:
  - Accepting or refusing care and treatment offered to you
  - Resolving problems with care decisions
  - Having family input in care decisions if you desire
  - Give or withhold consent to participate in research projects or procedures
- Spiritual or pastoral care.
- Receive visitors of your choice unless it is clinically necessary to restrict visitors.
- Give informed consent before a high risk procedure is done.
- Be free from restraint or seclusion unless medically necessary to ensure your or others' physical safety. If restraint or seclusion is medically necessary, you have a right to safe implementation by trained staff.
- Be informed of unanticipated outcomes of care, treatment or services.

- Have advance directives for health care and for your care providers to respect and follow those directives. You have the right to request no resuscitation or life-sustaining treatment. You have the right to end of life care.

- Donate organs and other tissues according to regulations including input from medical staff and direction by your family or surrogate decision makers.

- Receive a Beneficiary Notice of non-coverage (if you are a Medicare patient) and appeal a discharge you believe is premature.

- Expect that all communications and records pertaining to your care will be treated as confidential; you have the right to review your own medical record and have access to information contained in your record in a reasonable time frame.

- Make a complaint about your care and treatment without fear of retribution or denial of care and to have timely complaint resolution.
  - If you have a concern regarding care or service, you may notify any staff member of your concern or ask to speak with management staff directly.
  - You may also contact the Director of Quality and Risk at (360) 299-1343.

  Additional Options:
    - Washington State Department of Health phone number: 1-360-236-4700.
    - DNV GL (Island Hospital's accrediting agency) at 1-866-523-6842.
    - If you are a Medicare beneficiary and have a complaint, you may contact Livanta at 1-866-815-5440.

- Examine and receive an explanation of your hospital bill.

AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____ Medical Record #: _____

Former Name or Alias (if any): _____ Social Security #: _____

Daytime Telephone: _____ Birth Date: _____/_____/_____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I hereby authorize _____

_____

and/or Dr.(s) _____ to discuss my medical information with the following individuals:

Name:	**Relationship to Me:**	**Phone#:**

Expiration date of authorization or event: _____

SIGNATURE OF PATIENT AUTHORIZING DISCUSSION OF HIS/HER PERSONAL HEALTH CARE INFORMATION WITH THE ABOVE NAMED INDIVIDUALS:

_____	_____	_____
Date/Time	Signature of Patient or Legally Responsible Party	Relationship to Patient

ISLAND HOSPITAL

ISLAND HOSPITAL CLINICS
FINANCIAL POLICY

Thank you so much for choosing us as your health care provider. We are committed to providing you with the highest quality medical care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we believe it important for our patients to have a clear understanding of our expectations regarding their billing and payment arrangements. Please read and sign the following Financial Policy prior to your visit. Should you have any questions, please feel free to ask.

Patient Responsibilities: All patients must complete our "Patient Registration Form" before being seen by any of our healthcare providers. This must be updated at least once a year. *Full payment is due at time of service* unless you have a *current medical insurance card, which must be presented at each visit.* We accept cash, checks, and credit cards.
Contracted Insurance Companies: We will bill any insurance. If we are contracted with the patient's insurance company, we will accept as payment in full, all contracted insurance allowables (their payment, plus any co-insurance, deductibles and/or co-payments). If we are not contracted with the patient's insurance, payment must be made to the full amount of our charge. **If your policy has an office visit co-payment, you must pay the co-payment at the time of service.** Otherwise, an administrative fee may be billed. Please check with your specific insurance company to determine whether this clinic is a preferred provider.
Medicare: We accept Medicare assignment, which means the Medicare check will be sent to our office. If we are not contracted with your supplemental insurance company, we will courtesy- bill one time.
Payment by Check: If your check is returned for non-sufficient funds (NSF), we will charge a $20.00 fee to your account. If that happens, you will be asked to remit the amount of the original check, plus service charge, in cash or by credit card.

General Credit Policy: Finance Policy Review (Effective January 1, 2015)

Patients are required to pay balances in accordance with the following guidelines:

- Payments may be made using Cash, Checks, or Credit Cards. Statements may also be paid online.
  - Mastercard, Visa, American Express or Discover are accepted.
- Physician office and therapy visit co-pays are required on the date of service. Lack of co-pay payments for any visits may result in rescheduling of the service.
- Extended payment plans are available upon approval with a maximum extension of twelve (12) months and a minimum payment of $50.00 per month.
- Delinquent accounts will be referred to a collection agency at which time additional fees will be assessed.

If you are unable to meet these terms, please contact the Patient Accounting Office at (360) 299-1332, ((855)-440-4200 ext. 1332 to make arrangements
Fees: Our clinic is committed to providing you with the highest quality medical care. Our charges are based on a value scale developed by the American Medical Association and supported by most insurance companies. You are welcome to know what our normal charge is for any given service.
Minors: For a child of divorced parents, we expect all payments for co-payments, deductibles and non-covered services from whichever parent accompanies the child. We will not bill ex-spouses or parents but will be happy to provide you an itemized receipt upon payment for your reimbursement needs.

Repeated failure to keep scheduled appointments, repeated NSF checks, and/or failure to make timely payments on your account may result in the termination of medical care from our clinic for the entire family.

I HAVE READ AND FULLY UNDERSTAND THE
ISLAND HOSPITAL CLINICS FINANCIAL POLICY

Signature of Responsible Party | Print Patient Name / Date of Birth

Date Signed | Print Name of Responsible Party / Relationship

ISLAND HOSPITAL

One Patient/One Facility Per Request. *For internal purposes only: M#*_____

***Patient Name:** _____ ***Date of Birth:** _____ Telephone #: _____

***Purpose of Disclosure**: □ Insurance □ Provider □ Attorney □ Personal □ Other: _____

INFORMATION TO BE RELEASED *FROM*:	*** INFORMATION TO BE RELEASED *TO*:**
Facility Name: _____	**Island Hospital**
(Organization/Person)	Department/Clinic: _____
_____ *(Address)*	*(Organization/Person)*
_____ *(City, State, Zip)*	*1211 24th Street* *(Address)*
_____ *(Phone/Fax)*	*Anacortes, WA 98221* *(City, State, Zip)*
	_____ *(Phone/Fax)*

*** Type of information** *(check appropriate box):*

- □ **Pertinent Hospital Medical Records from date: _____ to date: _____**
- □ **Pertinent Clinic Medical Records from date: _____ to date: _____**
  (a fee may be charged for this service)
- □ **All Medical Records** *(a fee may be charged for this service)*
- □ **Images** *(specify type)* _____
- □ **Other** *(specify – discharge summary, operative reports, lab reports, billings, etc)* _____

****Patient Authorization*:**

I understand that my records may contain information regarding the diagnosis or treatment of the following conditions and give my consent to include them in this records request *(patient initials required):* ____ HIV/AIDS ____ sexually transmitted diseases ____ drug and/or alcohol abuse ____mental illness ____psychiatric condition

***This authorization is valid until _____ *(date) OR* when the following event occurs: _____**

(State when Island Hospital is no longer authorized to disclose your information based on this authorization. If no date or event is listed, the authorization will be effective for 30 days from the date signed by you)

Note: Authorization to disclose your information *to an employer or financial institution* can only be effective for a maximum of one year from the date signed by you. (Reference RCW 70.02)

Minors **(defined by law as a person under the age of 18 years unless otherwise noted for specific conditions):** A minor patient's signature is required in order to release the following information:

1. Conditions relating to birth control, abortion or prenatal services (at any age per Washington State Law)
2. Sexually transmitted diseases (if age 14 or older)
3. Alcohol and/or drug abuse and mental health conditions (if age 13 and older)

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to Island Hospital Privacy Officer, 1211 24th Street, Anacortes, WA. 98221.

I understand I have the following rights to:

- Inspect or receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I understand that once Island Hospital discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that the confidentiality of these records will be protected by Island Hospital and its clinics under the authority of Federal (HIPAA, 45 CFR parts 160 and 164) and/or State of Washington laws. I also understand that some of my records may be protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in these regulations.

By signing this page, I acknowledge that I have read and agree to the terms on this page.

***Signature** _____ ***Date**_____

(Patient or Person Authorized to give Authorization)

***If signed by person other than patient, provide reason, relationship to patient, or description of authority**: _____

ID Confirmed_____ ***Date Records Copied*** _____ ***Copied By*** _____ ***Department/Clinic*** _____

JOINT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Island Hospital respects your privacy. It is required to maintain the privacy of your health information and to provide you with a notice ("Notice") of its legal duties and privacy practices. We understand that your personal health information is very sensitive. Island Hospital will not use or disclose your health information except as described in this Notice. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records generated by Island Hospital and its personnel, volunteers, students and trainees. This Notice also applies to other health care providers that come to Island Hospital to care for patients, such as physicians, physician assistants, therapists, and other health care providers who are not employed by Island Hospital, such as ambulance services and emergency medical technicians who may have brought you to the Hospital, unless those other providers give you their own Notice that describes how they will protect your medical information. The Hospital and these other health care providers work together to provide you with care and they will share your health information with each other as necessary to care for you, to obtain payment for that care, or for health care operations purposes, such as quality assessment and utilization review.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. Island Hospital is required to follow the privacy practices that are described in this Notice (which may be amended from time to time).

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we create and store are the property of Island Hospital. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to agree to any restriction you may request, except if your request is to restrict disclosing protected health information to a health plan for the purpose of carrying out payment or health care operation, the disclosure is not otherwise required by law, and the health information pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You must make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to amend your health information. You must give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures made for purposes of treatment, payment or health care operations, disclosures you authorized, disclosures to you, incidental disclosures, disclosures to family or other persons involved in your care, disclosures to correctional institutions, and law enforcement in some circumstances, disclosures of limited data set information or disclosures for national security. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- Receive a notification if we discover a breach of your protected health information, according to requirements under federal law.

For help with these rights during normal business hours, please contact:

Privacy Officer, Island Hospital
1211 24th Street
Anacortes, WA 98221
(360) 299-1300

PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

We may use and disclose your protected health information without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are legally permissible.

For Treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For Payment:

- We request payment from your health insurance plan with your consent. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Appointments:

- We may use your information to contact you to provide appointment reminders.
- We may use your information to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Health Care Operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

REQUIRED OR PERMITTED BY LAW:

- **Medical Researchers** - If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Funeral Directors/Coroners** - Consistent with applicable law to allow them to carry out their duties.
- **Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **The Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **Comply With Workers' Compensation Laws** if you make a workers' compensation claim.
- **Public Health and Safety Purposes as Allowed or Required by Law:**
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities.
  - To protect public health and safety.
  - To prevent or control disease, injury or disability.
  - To report vital statistics such as births or deaths.
- **Report Suspected Abuse or Neglect** to public authorities.
- **Correctional Institutions** - If you are in jail or prison, as necessary for your health and the health and safety of others.
- **Law Enforcement Purposes** - Such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **Health and Safety Oversight Activities** - For example, we may share health information with the Department of Health.
- **Work Related Circumstances Under the Following Conditions:**
  - The employer must have requested the health care service that was provided to the patient.
  - The healthcare service provided must relate to the medical surveillance of the workplace or be an evaluation to determine whether the individual has a work-related illness or injury.
  - The employer must have a duty under the Occupational Safety and Health Administration (OSHA), or requirements of a similar State law, to keep records on or act on such information.
- **Military Authorities of U.S. and Foreign Military Personnel** - For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request or in accordance with state and federal law.
- **Specialized Government Functions** - For example, we may share information for national security purposes.

For fundraising:

- We may use your protected health information to contact you in an effort to raise money for our operations. We may also disclose your health information to a foundation that is related to us so that the foundation may contact you in an effort to raise money for our benefit. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

PERMISSIBLE USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION, BUT FOR WHICH YOU HAVE AN OPPORTUNITY TO OBJECT:

You have the right to object to our use or disclosure of your protected health information for the following purposes. If you object, we will not use or disclose it for the purpose(s) you specify.

- **Notification of Family and Others.** We may release health information about you to a family member, other relative, close personal friend, or any other person you identify to us who is involved in your medical care, which is directly relevant to such person's involvement with your health care. We may also give information to someone who helps pay for your care. We may tell your family or friends your general condition and that you are in a hospital.
- **Disaster Relief Efforts.** We may disclose health information about you to assist in disaster relief efforts.
- **Directory.** Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
  - your name,
  - location,
  - general condition, and
  - religion (only to clergy).

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION:

We may use and disclose your protected health information for the following purposes only after we obtain your written authorization for such uses:

- **Psychotherapy Notes**. We must obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes, (2) for our own training programs in which mental health students, trainees or practitioners learn under supervision to practice or improve their counseling skills, (3) to defend ourselves in a legal proceeding initiated by you, (4) required by law, (5) to a health oversight agency with respect to the oversight of the originator of the psychotherapy notes, (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.
- **Marketing Communications; Sale of PHI.** We must obtain your written authorization prior to using or disclosing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and disclosures not described in this Notice will be made with your written authorization. You may revoke any such authorization at any time by providing us with written notification of such revocation.

OUR RESPONSIBILITIES

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice and place the updated Notice on our website and post it in appropriate locations. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our Admitting or Medical Records departments to pick one up.

TO ASK FOR HELP OR REPORT A CONCERN

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Privacy Officer
Island Hospital
1211 24th Street
Anacortes, WA 98221
(360) 299-1300

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at Island Hospital. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

WEB SITE

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.islandhospital.org.

Name _____

BD / MR# _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices for Island Hospital.

_____ _____

Signature of patient (or personal representative) Date

_____ _____

Printed Name Relationship to patient

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This form will be retained in your medical record.

Adult History Information

Patient Name: _____ Date of Birth: _____

Clinic: _____ Today's Date: _____

To help us provide you with the best care, please fill out this form to the best of your ability. If you feel uncomfortable or confused with the any of the questions, please leave them blank and inform your provider of any concerns. Thank you.

Personal Medical History: Please check any box that applies ☐ No Known Medical History

Cancer:

	Year of Onset:
☐ Bladder Cancer	
☐ Blood Cancer	
☐ Brain Cancer	
☐ Breast Cancer	
☐ Cervical Cancer	
☐ Colorectal Cancer	
☐ GI Cancer	
☐ Head/Neck Cancer	
☐ Kidney Cancer	
☐ Leukemia	
☐ Liver Cancer	
☐ Lung Cancer	
☐ Lymphoma	
☐ Melanoma	
☐ Musculoskeletal Cancer	
☐ Oral Cancer	
☐ Ovarian Cancer	
☐ Pancreatic Cancer	
☐ Prostate Cancer	
☐ Skin Cancer	
☐ Stomach Cancer	
☐ Thyroid Cancer	
☐ Uterine Cancer	
☐ Other Cancer: _____	

Cardiovascular:

	Year of Onset:
☐ Abdominal Aortic Aneurysm	
☐ Aortic Regurgitation	
☐ Aortic Stenosis	
☐ Atrial Fibrillation	
☐ Cardiac Arrhythmias	
☐ Carotid	
☐ Coronary Artery Disease	
☐ Deep Vein Thrombosis	
☐ Heart Failure- Diastolic	
☐ Heart Failure- Systolic	
☐ Hyperlipidemia	
☐ Hypertension	
☐ Myocardial Infarction	
☐ Pacemaker	
☐ Peripheral Vascular Disease	
☐ Pulmonary Embolism	
☐ Pulmonary Hypertension	
☐ Other Cardiovascular Hx: _____	

Endocrine:

	Year of Onset:
☐ Diabetes Mellitus	
☐ Diabetes Isipidus	
☐ Graves Disease	
☐ Hyperthyroidism	
☐ Hypothyroidism	
☐ Low Testosterone	
☐ Pituitary Adenoma	
☐ Thyroid Nodule	
☐ Other Endocrine History: _____	

Gastrointestinal:

	Year of Onset:
☐ Barrett's Disease	
☐ Cirrhosis	
☐ Colitis	
☐ Colon Polyps	
☐ Crohn's Disease	
☐ Diverticular Disease	
☐ Esophageal Ring/Web	
☐ Gastric Ulcer	
☐ Gastroparesis	
☐ GERD	
☐ GI Bleeding	
☐ Gluten Enteropathy	
☐ Hemorrhoids	
☐ Hepatitis C	
☐ Irritable Bowel Disease	
☐ Liver Disease	
☐ Pancreatitis	
☐ Peptic Ulcer Disease	
☐ Ulcerative Colitis	
☐ Other Gastrointestinal Hx: _____	

Genetic:

	Year of Onset:
☐ BRCA	
☐ Cystic Fibrosis	
☐ Down Syndrome	
☐ Polycystic Kidney Disease	
☐ Other Genetic History: _____	

Genitourinary:

	Year of Onset:
☐ Benign Prostatic Hypertrophy	
☐ Elevated PSA	

Genitourinary: (Cont.)

	Year of Onset:
☐ Fecal Incontinence	
☐ Frequent UTI	
☐ Hematuria	
☐ Hemodialysis	
☐ Kidney Disease	
☐ Kidney Failure	
☐ Kidney Stones	
☐ Peritoneal Dialysis	
☐ Prostate Nodule	
☐ Proteinuria	
☐ Urinary Incontinence	
☐ Other Genitourinary Hx: _____	

Gynecologic: (females only)

	Year of Onset:
☐ Abnormal Pap	
☐ Chlamydia	
☐ Dyspareunia	
☐ Endometriosis	
☐ Fibroids	
☐ Genital Warts	
☐ Gonorrhea	
☐ Heavy Menstrual Cycles	
☐ Herpes/HSV	
☐ Human Papillomavirus	
☐ Inferiliity	
☐ Irregular Menstrual Cycles	
☐ Ovarian Cysts	
☐ Painful Menstrual Cycles	
☐ Other Gynecologic: _____	

HEENT: (Head/eyes/ears/neck/throat)

	Year of Onset:
☐ Blindness – Partial	
☐ Blindness – Total	
☐ Cataracts	
☐ Glaucoma	
☐ Hearing Loss	
☐ Recurrent Ear Infections	
☐ Recurrent Sinusitis	
☐ Retinal Detachment	
☐ Ruptured TM (Eardrum)	
☐ Tinnitus	
☐ Vertigo	
☐ Vocal Cord Paralysis	
☐ Other HEENT History: _____	

Adult History Information

Patient Name: _____ Date of Birth: _____

Clinic: _____ Today's Date: _____

To help us provide you with the best care, please fill out this form to the best of your ability. If you feel uncomfortable or confused with the any of the questions, please leave them blank and inform your provider of any concerns. Thank you.

Personal Medical History: Please check any box that applies ☐ No Known Medical History

Hematology:

	Year of Onset:
☐ Anemia	
☐ Essential Thrombocytosis	
☐ Factor V Leiden	
☐ Hemochromatosis	
☐ Hemophilia	
☐ Myelodysplasia	
☐ Myelofibrosis	
☐ Neutropenia	
☐ Other Coagulation Disorder	
☐ Sickle Cell Anemia	
☐ Thalassemia	
☐ Thrombocytopenia	
☐ Other Hematology Hx:	

_____

Infectious Disease:

	Year of Onset:
☐ Chickenpox	
☐ Hepatitis A, B, or C	
☐ Herpes	
☐ HIV	
☐ Malaria	
☐ Measles	
☐ MRSA	
☐ Mumps	
☐ Polio	
☐ Positive PPD	
☐ Rheumatic Fever	
☐ Rubella	
☐ Syphilis	
☐ Tuberculosis	
☐ Vanco-Resistant Enteroc.	
☐ Other Infectious Disease Hx:	

_____

Musculoskeletal:

	Year of Onset:
☐ Ankle Pain	
☐ Carpal Tunnel	
☐ Cervical Spine Disease	
☐ Chronic Back Pain	
☐ Cubital Tunnel	
☐ Fibromyalgia	

Musculoskeletal: (Cont.)

	Year of Onset:
☐ Foot Pain	
☐ Fractures	
☐ Gout	
☐ Lumbar Spine Disease	
☐ Osteopenia	
☐ Osteoporosis	
☐ Scoliosis	
☐ Shoulder Pain	
☐ Other Musculoskeletal Hx:	

_____

Neurologic:

	Year of Onset:
☐ ADHD	
☐ Autism	
☐ Dementia	
☐ Developmental Delay	
☐ Familial/Benign Tremor	
☐ Headaches	
☐ Migraines	
☐ Multiple Sclerosis	
☐ Parkinson's Disease	
☐ Peripheral Neuropathy	
☐ Restless Leg Syndrome	
☐ Seizures	
☐ Stroke	
☐ Transient Ischemic Attack	
☐ Other Neurologic History:	

_____

Psychiatric:

	Year of Onset:
☐ Anorexia Nervosa	
☐ Anxiety	
☐ Bipolar Disorder	
☐ Bulimia	
☐ Depression	
☐ Personality Disorder	
☐ PTSD	
☐ Schizophrenia	
☐ Substance Abuse	
☐ Other Psychiatric History:	

_____

Respiratory:

	Year of Onset:
☐ Abnormal Chest X-ray	
☐ Allergies/Hay Fever	
☐ Asbestosis	
☐ Asthma	
☐ Chronic Cough	
☐ COPD	
☐ Cystic Fibrosis	
☐ Oxygen Deepened	
☐ Pneumothorax	
☐ Pulmonary Fibrosis	
☐ Sarcoidosis	
☐ Sleep Apnea	
☐ Valley Fever	
☐ Wegener's Granulomatosis	
☐ Other Respiratory Hx:	

_____

Rheumatologic:

	Year of Onset:
☐ Fibromyalgia	
☐ Gout	
☐ Lupus	
☐ Osteoarthritis	
☐ Polymyalgia Rheumatica	
☐ Rheumatoid Arthritis	
☐ Sjögren's Syndrome	
☐ Other Rheumatologic Hx:	

_____

Skin/Integumentary:

	Year of Onset:
☐ Acne	
☐ Actinic Keratosis	
☐ Alopecia	
☐ Eczema	
☐ Melanoma	
☐ Plantar Warts	
☐ Psoriasis	
☐ Rosacea	
☐ Vitiligo	
☐ Other Skin History:	

_____

Patient Name: _____ Date of Birth: _____

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Social History: Please answer or fill in blank as appropriate ☐ No Known Social History

PERSONAL HISTORY:

Education Level:	Less than High School	High School/GED	Some College	2-Year College	4-Year College
	Professional Degree	Masters Degree	Doctoral Degree	Other: _____	
Leisure Activities:					
Travel History:					
Marital Status:	Divorced	Married	Separated	Single (never married)	Widowed Other:
Pets:	Yes / No				
Military Service:	Yes / No	Branch:			
Occupation:					
Faith/Tradition/Religion:					
Household Members/Details:					

SAFETY:

Home Safety:		**Home Safety (continued):**	
Is your water heater temp set below 120?	Yes / No	Do you have a carbon monoxide detector in your home?	Yes / No
Do you have working smoke detectors in your home?	Yes / No	Do you have firearms in your home?	Yes / No
Do you have a fire extinguisher in your home?	Yes / No	Are firearms unloaded and locked?	Yes / No

PERSONAL HISTORY:				
Do you have concerns about your personal safety?	Yes / No	Comments:		
VEHICLE SAFETY:				
Seatbelt use:	Always	Never	Sometimes	Other:
Helmet use:	Always	Never	Sometimes	Other:
Additional Comments:				

SUBSTANCE USE:

TOBACCO USE:				
Tobacco Status:	Current every day smoker	Current some day smoker	Heavy tobacco smoker	Light tobacco smoker
	Former Smoker	Smokeless tobacco user	Unknown if ever smoked	Never smoker
	Smoker, current status unknown	Comments:_____		
Smoking packs/day:				
Smoking/Tobacco history or details:				
Quit status:	Considering quitting	Not considering quitting	Quit date established	Other:
ALCOHOL USE:				
Alcohol intake:	1-2 drinks per day	2+ drinks per day	1-3 drinks per week	Rare/Occasional
	None	Other:_____		
Additional Comments:				
SUBSTANCE USE:				
Substance or recreational drug use:	Amphetamines	Club/designer drugs	Cocaine/crack	Denies use
	Hallucinogens	Inhalants	Injection Drugs	Marijuana
	Opiates	Painkillers	Tranquilizers/sedatives	None
	Other:_____			
Additional Comments:				

Adult History Information

Patient Name: _____ Date of Birth: _____

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Social History: Please answer or fill in blank as appropriate ☐ **No Known Social History**

DIET AND EXERCISE:

During the past year has your weight?	Remained stable	Decreased less than 10 pounds	Increased more than 10 pounds
Other: _____			

DIETARY HABITS:

How often do you eat a well balanced diet?	About half the time	Daily or most days	Rarely or never	Other:	
How often do you eat fruit and vegetables?	0-1 servings daily	2-4 servings daily	5 or more servings daily	Other:	
How often do you drink soda/pop?	1-2 drinks per day	2+ drinks per day	1-3 drinks per week	Rare/Occasional	Never
	Other: _____				
How often do you drink caffeinated beverages?	1-2 drinks per day	2+ drinks per day	1-3 drinks per week	Rare/Occasional	Never
	Other: _____				
How often do you eat/dine out?	1-3 times a week	4 or more times a week	Rarely or never	Other:	
Additional Comments:					

EXERCISE/PHYSICAL ACTIVITY:

Please list your physical activities/exercise:					
Frequency?	Daily	1-2 times per week	3-4 times per week	5-6 times per week	Other:
Duration?	15-30 minutes a day	30-45 minutes a day	45-60 minutes a day	60-90 minutes a day	
	Other: _____				

DISABILITIES:

Do you live with any of the following disabilities? Yes / No (Please circle)	
Check those that apply and explain	
Hearing Deficiencies	☐
Vision Deficiencies	☐
Hemiparesis	☐
Paralyzed/Partially Paralyzed	☐
Paraplegia	☐
Quadriplegia	☐
Other Disabilities	☐

Patient Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY: ☐ **NO KNOWN FAMILY HISTORY**

Please check the medical conditions that run in your family and who had it:

	Age if still Living	Age at Death	Present Condition or Cause of Death	Cancer (specify)	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Mental Health Issues	Stroke	Other (please specify)
Father											
Mother											
Brother(s)											
Sister(s)											
Maternal Grandfather											
Maternal Grandmother											
Paternal Grandfather											
Paternal Grandmother											
Child											

Additional Comments: _____

_____

_____

_____

SURGICAL HISTORY: ☐ **NO KNOWN SURGICAL HISTORY**

Please list any surgeries/surgical procedures you have had and the approximate date/year:

Type of surgery and location: **Date:**

*Please specify right or left where applicable

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had anesthesia for surgery? ~ Yes / No (circle)

If any complications please explain: _____

Patient ID Sticker


Employee Parking
In-Car Access
26th Street
26th Street
Visitor Parking
Visitor Parking
Emergency Entrance
Visitor Parking
Visitor Parking
ONE WAY
Medical Arts Pavilion
Medical Office Building
Visitor Parking
Visitor Parking
Island Hospital
Island Medical Center
Physician Parking
25th Street
Visitor Parking
Commercial Avenue
M Avenue
Main Entrance
Employee Parking
Visitor Parking
24th Street
24th Street
ISLAND HOSPITAL
Parking Map
23rd Street
EV Charging Station
Handicap Parking
S
E
W
N
Sleep Wellness Center
Physical Address:
1110 22nd Avenue, Anacortes, WA 98221
(1 block NORTH of Hospital Main Campus)
22nd Street
22nd Street
O Avenue
Visitor Parking
N Avenue
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