## Welcome to Lincoln Family Medicine Center

We are excited to meet you and would like to personally thank you for choosing us to be part of your medical home! We hope you find the following information helpful in preparing you for your first appointment.

We provide comprehensive care from preventative and wellness visits to acute and chronic illness management. As your medical home, we will care for you in the office, hospital, nursing home or home visits when appropriate. We provide x-ray, laboratory and a variety of in-office surgical procedures as well as complete maternity care, delivery of your baby and well-child visits afterward. We are also happy to organize any referrals and specialist care efficiently.

**Medical history and current medications:** At your first visit, your medical team will want to talk with you about your health history. It is important to complete this form, including the release of records from your previous doctor, and a list of all your current medications and supplements. An alternative is to physically bring in all your medications in the bottles so your medical team can be sure to take the best care of you.

**Clinic Hours and Appointments:** Our clinic appointment hours are Monday through Friday from 8:00am - 4:30pm. If you have a message for your medical team after hours, you can communicate by sending us messages through our online portal any time of day or night. Please let us know if you are going to miss an appointment, at least 8 hours' notice would help us schedule other patients who might need to be seen. Patients who miss 3 or more appointments without calling may be dismissed from our clinic.

**What about emergencies?** We have a doctor and counselor on call 24/7 for your convenience if you need us after hours. Unless you have a life-threatening emergency or severe injury requiring immediate medical assistance, please call our office or on-call doctors first at 402-483-4571 before going to an Urgent Care or hospital.

**Obstetric Specific Care:** We look forward to caring for your in your pregnancy. You will be assigned a primary OB provider and a co-manager who will work together to care for you. At least one of your providers (usually both) will plan to be present at the delivery of your baby. Our team works with local obstetricians and maternal fetal medicine specialists as needed to provide you with the most complete care of you and your baby.

**Thank you for choosing Lincoln Family Medicine Center!** We recognize you and your family are at the center of the health care team. We appreciate any feedback regarding your care. We will work hard to provide you with quality, person-centered medical care to improve your health and well-being. If you have any questions, please contact us.

**Lincoln Family Medicine Center**
4600 Valley Road, Suite 200
Lincoln, NE 68510
(402) 483-4571

**Patient Information:**

Legal Name _____ Date of Birth _____
*LAST* *FIRST* *MIDDLE INITIAL*

Preferred Name _____ Previous Names _____

Street Address _____Apt/Unit Number_____

City _____State _____ ZIP _____

Home Phone _____ Cell Phone _____ Ok to text? ☐Yes ☐No

Email _____ Social Security # _____

Marital Status:☐Married ☐Single ☐Divorced ☐Domestic Partner Ethnicity:☐Hispanic☐Non-Hispanic

Preferred Language _____ Do you need an interpreter? ☐Yes ☐No

Race:☐Caucasian ☐African-American ☐Native American ☐Asian Pacific Islander ☐Multi-Racial ☐Other_____

**Emergency Contact (not in household):** Name _____

Phone _____ Relationship _____

**Father of Baby Information:**

Legal Name _____
*LAST* *FIRST* *MIDDLE INITIAL*

Phone number _____ Occupation _____

Does the father of the baby have any medical problems? ☐Yes ☐No If yes, please list_ _____

_____

Will the father of the baby be involved in your medical care and present at delivery? ☐Yes ☐No

**Support Person: (Please list who will be your primary support partner through your pregnancy)**

Name _____ Relationship _____

Phone Number _____

How did you decide to have your obstetric care at LFMC? ☐I was already a patient here ☐Family/Friend

☐Google ☐Flyer in the community ☐Other_____

## Guarantor Information (Correspondence)

How are you related to the patient? ☐Self ☐Spouse ☐Parent ☐Child ☐Other_____

Street Address _____Apt/Unit Number_____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ Social Security # _____

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Employer's Name _____

## Insurance Information

☐I do not have insurance

☐I have insurance (front desk will need to scan your card)

Primary Insurance Company_____

Policyholder's Name _____ Birthdate _____

Relationship to Patient:☐Self☐Spouse☐Child☐Other

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Insurance ID_____ Group ID_____

Secondary/Supplemental Insurance Company _____

Policyholder's Name _____ Birthdate _____

Relationship to Patient:☐Self☐Spouse☐Child☐Other

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Insurance ID_____ Group ID_____

**Preferred Pharmacy** (name & location)

**Preferred Hospital**

## Personal Health History Questionnaire

| Social History |
|---|
| **Tobacco History** ☐Never used ☐Current use, since_____ ☐Past use, quit year_____<br><br>Please specify type (check all that apply) ☐cigarettes ☐chew ☐cigar ☐e-cigarette/vape ☐pipe |
| **Sexual History** ☐Heterosexual ☐Bisexual ☐Homosexual ☐Celibate<br><br>Multiple sexual partners? ☐Yes ☐No |
| **Alcohol Use** ☐No/Never used<br>☐Yes, but stopped when I found out I was pregnant. Last drink? _____<br>☐Yes, current use. How much do you drink? _____ |
| **Recreational Drug Use** ☐Never used<br>☐Yes, but stopped when I found out I was pregnant. Last use? _____<br>☐Yes, current use. Please specify type (check all that apply)<br>☐marijuana ☐cocaine ☐methamphetamine ☐opiates ☐other: |
| **Safety Screen** Whom do you live with?<br><br>Do you feel safe at home? ☐Yes ☐No<br>Have you ever felt afraid of your partner? ☐Yes ☐No |

| Past Medical History | | |
|---|---|---|
| *Check all that apply to you currently or in the past:* | | |
| ☐ Acid Reflux (GERD) | ☐ Chicken Pox | ☐ Herpes/Cold Sores |
| ☐ ADHD | ☐ Constipation | ☐ Hepatitis |
| ☐ AIDS/HIV | ☐ Diabetes | ☐ High Blood Pressure |
| ☐ Anemia/Need for blood transfusion | ☐ Depression | ☐ Insomnia |
| ☐ Anesthesia Complications | ☐ Eating Disorder | ☐ Infertility |
| ☐ Anxiety | ☐ Endometriosis | ☐ Kidney Stones |
| ☐ Asthma | ☐ Genital Warts | ☐ Migraines/Headaches |
| ☐ Blood Clots | ☐ Heart Problems | ☐ Sexually Transmitted Disease |
| ☐ Cancer | ☐ Hemorrhoids | ☐ Thyroid Disease |

*Please list:*

Hospitalizations or surgeries _____

_____

Medications (include vitamins and over the counter) _____

_____

Drug Allergies (list reactions) _____

_____

| Gynecologic History | |
|---|---|
| When and where was your last pap smear? | Date: Location: |
| Have you ever had an abnormal pap smear? | ☐Yes ☐No |
| Have you had the HPV/Gardasil vaccine? | ☐Yes ☐No |
| What was the first day of your last period? | Date: |
| Were you having regular monthly periods prior to getting pregnant? | ☐Yes ☐No |
| Have you been on birth control in the past? | ☐Yes ☐No |
| If yes, please select type: | ☐Pill ☐IUD ☐Nexplanon ☐Depo shot ☐Patch ☐Vaginal Ring |
| When did you stop using birth control? | Date: |

| Genetic History<br>Is there any family history on either side of the following: | | | | | |
|---|---|---|---|---|---|
| | **YES** | **NO** | | **YES** | **NO** |
| Thalassemia | | | Muscular Dystrophy | | |
| Neural Tube Defect (open spine) | | | Cystic Fibrosis | | |
| Congenital Heart Defect | | | Huntington's Chorea | | |
| Down Syndrome | | | Intellectual Impairment or Autism Spectrum | | |
| Tay-Sachs Disease | | | Fragile X | | |
| Canavan Disease | | | Other inherited genetic or chromosomal disorder | | |
| Sickle Cell Disease or Trait | | | Babies born with birth defects | | |
| Hemophilia or Bleeding Disorders | | | Recurrent pregnancy loss or stillbirth | | |

| Obstetric History (please list all past pregnancies) | | | | |
|---|---|---|---|---|
| | Number | | Number | |
| Total pregnancies (including current pregnancy) | | Miscarriages | | |
| Deliveries | | Abortions | | |
| Premature Births (<37wks) | | Living Children | | |

| Date of Birth | Sex of baby | Birth weight | Weeks pregnant | Type of Delivery (Vaginal or C-section) | Complications or comments |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Any history of depression before, during or after pregnancy? ☐Yes ☐No
If yes, how was it treated?

| Pregnancy Risk Review | YES | NO |
|---|---|---|
| Will you be over the age of 35 at delivery? | | |
| Have you had vaginal bleeding that required evaluation (ER or clinic) since becoming pregnant? | | |
| Have you had severe nausea or vomiting that required evaluation (ER or clinic) | | |
| Have you had a rash, viral illness or a fever higher than 100° since your last period? | | |
| Have you ever been diagnosed with genital herpes? | | |
| Have you had exposure to someone with Tuberculosis? | | |
| Were you taking any meds while you were pregnant? If yes, please list: | | |
| **Past Pregnancies:** | | |
| Have you ever had high blood pressure during pregnancy? | | |
| Were you ever diagnosed with Pre-eclampsia? | | |
| Were you ever diagnosed with Gestational Diabetes? | | |

| Post Partum Planning | YES | NO |
|---|---|---|
| Do you plan to breastfeed/pump? | | |
| Do you plan to begin birth control after your baby is born?<br>If yes, please select type: ☐Pill ☐IUD ☐Nexplanon ☐Depo shot ☐Patch ☐Vaginal Ring | | |

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4600 Valley Road, Lincoln, NE 68510 • Ph: (402) 483-4571 • Fax: (402) 483-5079

# Authorization to Release Information to Family Members

Patient Name: _____Date of birth: _____

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 HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information released to any family members, you must sign this form. Please note that this authorization will remain in effect until it is revoked in writing by the patient.

**I authorize Lincoln Medical Education Partnership to disclose:**

❑ My complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions

❑ My complete health record except for the following information

- ❑ Mental health records
- ❑ Communicable diseases including, but not limited to, HIV and AIDS
- ❑ Alcohol/drug abuse treatment records
- ❑ Other: _____

**to the following individuals:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Client or Legal Guardian Signature Date

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# Medical Record Release Authorization

Patient Name _____Date of Birth_____

SSN# _____Home Phone _____Cell Phone_____

Address _____City/State/Zip _____

Email Address _____

## A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone# _____Fax# _____

## B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____Fax# _____

## C) For the purpose of:

___Litigation

___Insurance

___Self/Personal Copy*

___Transfer or Continuity of Care

___Other _____

___Disability

___Work Comp

___Behavioral Health/ Substance Use

***Subject to Fees***

Date Range _____ to _____

- ❑ Physician Office Notes
- ❑ Immunizations
- ❑ Operative/Procedure Reports
- ❑ Other _____
- ❑ Cardiology/EKG Reports
- ❑ Lab/Path Reports
- ❑ Radiology
- ❑ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, including 42 C.F.R. Part 2. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

_____ _____

(Signature of Patient/Parent/Guardian or Authorized Representative) (Date)

This authorization will expire one year from the above date unless I specify an expiration date: _____

lincoln family medicine center

**For the reasons listed below, we are unable to grant for requests for care by <u>only</u> a female or a male physician.**

We often receive requests by female patients to have a female physician. Because most of our physicians in this office are in training, they must be supervised by faculty physicians. To ensure the quality of training for our physicians and the quality of medical care provided to our patients, a faculty physician will need to be present during some medical examinations, all medical procedures such as surgery, and all deliveries of our obstetrical patients. At this time, about half of our faculty physicians are men.

Additionally, in cases of emergency, our patients will be expected to see the physician on duty during evening and weekend hours. In many instances this will be a male physician.

By signing below, you will be accepting our guidelines as listed above. If you are unable to accept these guidelines, we will not be able to provide services to you through our clinic.

إلى مرضانا الأناث

في الأيام الأخيره جاءتنا عدد من طلبات المرضى الأناث للطبيبات بدلا من الأطباء. نظرا لمحدوديه عدد الطبيبات في عيادتنا، لا يمكننا ضمان الأستفاده من خدمات الطبيبات الأناث فقط. هذا خاصه صحيح بالنسبه للحالات الاضطراريه أو عند الحاجه للعلاج في الاوقات غير الأعتياديه مثل الليالي أو العطلات الاسبوعيه. و بالاضافه، معظم الاطباء في عيادتنا تحت التدريب، فيجب الاشراف عليهم باحد الاساتذه. لهذا فمن الممكن أن يكون المشرف طبيب و ليس طبيبه. لكي نضمن نوعيه التدريب لاطباءنا و الخدمه الصحيه الممتازه لمرضانا، فاحيانا يستوجب وجود طبيب أو طبيبه من الاساتذه أثناء الكشف الطبي أو الاجراءات العلاجيه.

في الحالات الاضطراريه فاننا نتوقع أن الطبيب أو الطبيبه الموجوده بالخدمه سيقوم بالكشف الطبي علي مرضانا الاناث. من الممكن أن يستطيع الطبيب أو الطبيبه الموجوده بالخدمه أستشاره الطبيب المعالج.

نحب أن نأكد أننا سنحاول ما في أستطاعتنا أن نلبي طلبات مرضانا عند الاستطاعه.

توقيع .....

Signature of Patient _____ Date _____

Signature of Spouse/Significant Other _____

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INFORMED CONSENT TO HIV ANTIBODY TEST AND RELEASE OF INFORMATION

I, _____, voluntarily give the Lincoln Family Medicine Center permission to test my blood for antibodies to HIV (the presumed cause of AIDS).

The human immunodeficiency virus (HIV) has been recognized to be associated with acquired immune deficiency syndrome (AIDS). AIDS weakens the body's ability to fight off infection and diseases. Tests are now available to determine the presence of antibodies to HIV in the blood. The ELISA test is the initial screening test, and it is followed by a Western Blot test. The Western Blot is a confirmatory test to detect presence of antibodies to HIV in the blood.

Generally, a positive HIV antibody test indicates a previous exposure to the virus and the body's immune response to it. At the present time, the consequences for a person testing HIV antibody positive are not clearly defined. The test cannot tell you if you will eventually develop signs of illness related to HIV or if you do, how serious that illness might be. I understand the HIV blood test can in some cases indicate that a person has antibodies to the virus when the person does not (false positive) or fail to detect a person has antibodies to the virus when the person is indeed infected with the virus (false negative).

I further understand that anonymous testing is also available at the Lincoln Lancaster County Health Department (402-441-8065). If I am tested at the Health Department, results will only be made known to me.

HIV is transmitted by an exchange of body fluids (blood, semen, vaginal secretions for example). This exchange may occur during sexual relations, IV drug use with unclean needles, or very rarely from blood transfusions. Other mechanisms of infection are theoretically possible. You can reduce your exposure to HIV by being sexually abstinent, by being sexually active with only one person who does not carry HIV, by using condoms when having sex, by not sharing needles if injecting IV drugs, and by avoiding other peoples' blood and body fluids.

I understand if the test is positive, in combination with other data, a diagnosis of AIDS by my medical provider is possible. If so, it is required my case be reported to the Lincoln Lancaster County Health Department and will be investigated by them.

I understand the Lincoln Family Medicine Center will take reasonable precautions to protect the confidentiality of my test results. I understand there will be no unauthorized disclosure of these test results unless disclosure is specifically allowed or required by law.

_____ _____

Signature of patient or person authorized to give consent | Relationship to patient (if appropriate)

_____ _____

Date | Witness

# Edinburgh Postnatal Depression Scale[1] (EPDS)

Name:_____ Address:_____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone:_____

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As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry 150:782-786.*

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199