University of Nebraska Omaha

Confidential Medical History
Health Services
102 HPER
6001 Dodge Street Omaha NE 68182-0301
504-554-2374

Name: _____

Birthday: ____/_____/_____

NU ID #: _____

Please list all medication that you are currently taking: _____

_____

Are you allergic to any medications? ☐ No ☐ Yes, please list: _____

Do you have any other allergies? ☐ No ☐ Yes, please list: _____

Personal History: Have you had any of the following? Please mark the appropriate box.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart/Lungs			Sinus Infections			Stroke or TIA		
Heart Disease			**Stomach/Bowel**			**Mental Health**		
Heart Murmur			Colitis			Anorexia		
High Blood Pressure			Gallbladder Disease			Bulimia		
Blood Clots			Ulcers			Depression		
Asthma			Irritable Bowel			ADD		
Pneumonia			Syndrome			Anxiety		
Rheumatic Fever			Jaundice			**Infectious Disease**		
Rheumatic Heart			Liver Disease			Chicken Pox		
Endocrine			Reflux Disease			Hepatitis A, B, C		
Adrenal Disorders			**Orthopedic**			Infectious Mononucleosis		
Diabetes			Arthritis			Malaria		
Thyroid Disorder			Fractures			Mumps		
Kidney/Bladder			**Skin**			Tuberculosis		
Kidney or Bladder Disease			Eczema/Psoriasis			Sexually Transmitted Disease		
			Hives			Carrier of Infectious Disease		
			Hematology/ Oncology			Have you had HPV vaccine		
Kidney Transplant						**Please List any Surgeries:**		
Bladder or kidney infections			Anemia			_____		
			Blood Disorders			_____		
Ears/Eyes/Nose/ Throat			**Neurologic**			_____		
			Seizures			_____		
Eye disorders (other than glasses)			Head Injury			_____		
			Headaches			**Please list any Hospitalizations:**		
Hearing Loss			Migraines			_____		
			Multiple Sclerosis			_____		
						_____		
						_____		
						_____		

Family History: Does your father, mother brothers, sisters or grandparents haven any of the following? If it is a grandparent, please state if it is on your mother's side or your father's side.

Condition	Yes	No	Who	Additional Information
Alcoholism				
Diabetes				
Breast Cancer				
Ovarian cancer				
Prostate Cancer				
Other Cancer				
Heart Disease				
High Cholesterol				
Kidney Disease				
High blood pressure				
Stroke				
Mental Illness/depression				
Blood clotting Disorder				
Other:				

STAFF USE ONLY

Comments/Updates:

CONTINUED ON THE BACK, PLEASE FLIP FORM OVER

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Social History:

How often do you exercise? _____ What type of exercise do you do? _____

Do you smoke or use smokeless tobacco? _____ How much per day? _____

When was the last time you used street/rec drugs? _____ What did you use? _____ How often do you use? _____

When was the last time you used marijuana? _____ How often do you use marijuana? _____

How many servings of caffeine do you have per day? _____

Do you drink alcohol? _____ If yes, how often do you drink alcohol? _____ How may drinks do you typically have? _____

Have you been physically or verbally abused? _____ Do you feel safe in your current relationship? _____

Sexual History:

Age of first intercourse? _____

Do you have sex with: ☐ Men ☐ Women ☐ Both

How many sex partners have you had in the past 90 days? _____

Are you currently sexually active? ☐ Yes ☐ No

Have you had a new partner in the past 90 days? ☐ Yes ☐ No

Have you completed the HPV vaccine series? ☐ Yes ☐ No

What do you do to prevent yourself from getting sexually transmitted infections? _____

Female Reproductive History

Menstrual History

What was the first day of your last period? ____

Do you think you may be pregnant? ☐ Yes ☐ No

What is your current birth control method? _____

What type of birth control would you like to use? _____

Age of first menstrual period? _____

Are your periods regular? ☐ Yes ☐ No

How long do your periods usually last? _____

Is your flow? ☐ Light ☐ Moderate ☐ Heavy

Do you have cramps with your period? ☐ Yes ☐ No

Pap History:

Have you ever had a pap smear? ☐ Yes ☐ No When: _____

Have you ever had any abnormal pap? ☐ Yes ☐ No When: _____

Have you ever had a pelvic exam? ☐ Yes ☐ No

Do you do breast self-exams? ☐ Yes ☐ No

Pregnancy History

Have you ever been pregnant? ☐ Yes ☐ No # of Pregnancies: ___ # of living children: ___

# of Vaginal deliveries:___ # of Cesarean sections:___ # of miscarriages: ___ # of abortions: ___

Please check any symptoms you are having today:

☐ Vaginal discharge ☐ Itching ☐ Burning
☐ Bumps ☐ Sores ☐ Pain with sex
☐ Pain with urination ☐ Frequent urination ☐ Urinary urgency

Do you have any other concerns today? _____

Male Reproductive History

Do you do self-testicular exams? ☐ Yes ☐ No

Have you had a prostate exam? ☐ Yes ☐ No When: _____ Was it normal: ☐ Yes ☐ No

Have you ever had (check all that apply): ☐ Enlarged prostrate ☐ Prostate cancer ☐ Infection of the prostate
☐ Epididymitis ☐ Testicular cancer

Please check any symptoms you are having today? ☐ Discharge ☐ Itching ☐ burning or pain with urination
☐ Bumps ☐ Sores

Do you have any other concerns today? _____

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Date_____

BILLABLE SERVICES: **Students'** required billable services includes ALL x-ray, laboratory tests, immunization, physicals and procedures such as earwax , toenail or wart removals. **Faculty/staff s'** required billable services includes ALL office visits, x-ray, laboratory tests, immunization, physical and procedures such as earwax , toenail or wart removals.

Based on lab results additional tests may be ordered by you practitioner as Standard of Care.

METHOD OF PAYMENT: WE ACCEPT CASH, CHECK, MAVCARD, CREDIT CARDS, and SOME FLEXIBLE SPENDING CARDS. Payment plans may be arranged on an individual basis with the Financial Consultant in our office prior to receiving billable services.

CASHIERING/STUDENT ACCOUNTS (MavLINK): As a student of the university you can also request that this office assess any or all balance due to your MavLINK account for payment. Once added to the MavLINK account your obligation would no longer be with this office. Therefore, you would be responsible for the UNO Cashiering/Student Accounts office payment requirements.

Human Resource/Payroll: As an employee of the university you can also request that this office assess any or all balance due to your employee payroll deduction for payment. The balance will automatically be deducted for payment .

REGARDING YOUR INSURANCE: Charges for medical services are the responsibility of the patient. However, claims are submitted automatically to your insurance company unless the patient request to pay out of pocket. Any balance remaining after processing of your claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. We cannot bill your insurance company unless you give us your complete insurance information. It is your responsibility to know your insurance benefits as it may not cover all of the services provided.

SELF-PAY: You will be asked to pay in full at the time of your visit for all services incurred including office visits, x-ray, laboratory exam, immunization, physical and procedures such as earwax , toenail or wart removals.

RETURNED CHECKS: A minimum of a $25.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pay by cash or credit card.

MISSED APPOINTMENTS: Please be advised that if you are unable to keep your appointment, kindly give us a 24 hours notice. A fee will be assessed for any appointments missed or not cancelled in a timely fashion.

OVERDUE ACCOUNTS: Patients with past due accounts will be asked to make payment in full before 60 or more days. Any balance remaining after 90 or more days will automatically be assessed to your MavLINK student account, or employee payroll deduction for the full amount. **COLLECTIONS:** We reserve the right to forward your account to a collection agency if it is past 90 or more days or determined to be uncollectable.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

Signature of Patient/Responsible Party	Printed Name	*Date*

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Information Form

Please complete the following:

Demographic Information:

Name: _____ **Middle Initial:** _____ **Date of Birth:** ____/____/____

Local Address: _____ **City:** _____ **St:** ___ **Zip Code:** _____

NU ID # __ __ __ __ __ __ __ __ **Email:** _____ **Phone #** _____ ☐Home ☐Cell ☐Work

Gender: ☐ Male ☐ Female
Transgender: ☐ MTF ☐ FTM

Relationship status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White (Caucasian) ☐ Other

Status: ☐ Student ☐ Faculty ☐ Staff

Employment Status: ☐ Employed: _____ ☐ Not Employed

Emergency Contact:

Name: _____ Phone # (____) ____-_____ Relationship: _____

Address: _____ City: _____ St: ____ Zip: _____

Insurance Information:

☐ I have student health insurance offered through UNO by BCBS. ☐ I do not have health insurance at this time.
☐ I have health insurance other than UNOs student health insurance.

Insurance Company: _____ **Policy #:** _____

Insurance Company Phone #: _____ **Employer:** _____

Policy Holder if other than you: ☐ Parent/Guardian ☐ Spouse

Name of policy holder: _____ Date of Birth: ____/____/_____ M/D/YR

Gender: ☐ Male ☐ Female ☐ MTF ☐ FTM Phone #: (_____) _____--_____

Address: _____ City: _____ ST: _____ Zip_____

Country: _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

If Guardian, indicate relationship to the patient: _____

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Informed Consent for Medical Examination and Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, nurse practitioners, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

2. NO GUARANTEE OF RESULTS: UNO Health Services physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care.

3. I understand that I can change my mind regarding the procedure or treatment. If I do, I must tell the person or the team doing the procedure or treatment *before* they start.

4. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

5. I understand that the clinic, as required by law, must report certain diseases to local and state agencies.

6. I understand that students and others may observe the procedure or treatment for educational purposes. Observers must be approved by this facility.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this document may be utilized the same as the original. I further acknowledge receipt of the Notice of Privacy Practices of UNO Health Services at this visit or at a previous visit.

Patient Information

Printed Name_____ Date of Birth:_____ NUID # _____

Signature: _____ Date: ___/___/____

Parent/Guardian must sign below for patients under the age of 19:

I certify that I have read and understand this document. I authorize University of Nebraska-Omaha Health Services and/or Counseling and Psychological Services (CAPS) to provide medical treatment, mental health and/or substance use treatment to my child:

Name of Minor Child: _____ Minor Child's Date of Birth: Date: ___/___/____

Parent/Guardian Name Printed: _____ Relationship: ☐ Parent ☐ Guardian

Parent/Guardian Signature: _____ Date: ___/___/____