Exam Date

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

Identification Data

Name

Name you prefer to be called

Address

City State Zip Code

Country

Home Telephone Number

Cell Phone Number

Date of Birth

E-mail Address

Age Marital Status

Religious Preference SSN

Referred By

Occupation

Employer

Phone Number

Preferred Phone Contact

Spouse/ Partner

Name

Occupation

Employer

Best Contact Phone Number

Social Security #

Date of Birth

Next of Kin Not At Same Address

Name

Address

City State Zip Code

Relationship

Phone Number

Country

Whom May We Contact If Necessary (If Other Than the Above)

Name

Address

City State Zip Code

Relationship

Phone Number

Country

Insurance Information

Primary Insurance Company

Contract or ID Number

Group Number

Secondary Insurance Company

Contract or ID Number

Group Number

Piedmont Gynecology & Obstetrics, P. C.

John B. Pugh, M.D.

Name [ ] Exam Date [ ]

Please take a few moments and fill out this form as completely as you can.

Main reason for seeking medical attention [ ]

☐ No Complaint. Desire a periodic examination.

AUTHORIZATION

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/ AIDS-confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to Piedmont Gynecology & Obstetrics, P.C. of all medical and/ or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Piedmont Gynecology & Obstetrics, P.C. by any insurance policy, self-insurance program or other benefit plan.

☐ My insurance plan requires a co-pay.

☐ My insurance plan requires a deductible.

The amount of my deductible is [ ]

I agree that I will pay any amount not paid by my insurance within 30 days of the receipt of a statement.

____
Person providing the authorization

Exam Date [ ]

____
Relationship to patient if not patient

GENERAL MEDICAL HISTORY

Name | Exam Date

INFECTIOUS DISEASES

Check any of the following diseases you have had:

- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Hepatitis
- ☐ Scarlet Fever
- ☐ Chicken Pox
- ☐ Meningitis
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease
- ☐ Abscess or Boils
- ☐ German Measles (Rubella)
- ☐ Bladder or Kidney Infection
- ☐ Rheumatic Fever
- ☐ Pneumonia

SURGERY

Have you had an operation on any of the following?

- ☐ Appendix
- ☐ Gallbladder
- ☐ Kidney
- ☐ Tonsils
- ☐ Tubal
- ☐ Thyroid
- ☐ Breast
- ☐ Varicose Veins
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Tumor of any kind
- ☐ Hemorrhoids
- ☐ Chest
- ☐ Bladder
- ☐ Piercings / tattoos

Other

ILLNESS

Have you ever had any of the following?

- ☐ Anemia
- ☐ Jaundice
- ☐ Diabetes
- ☐ Cancer
- ☐ Bone Disease
- ☐ Migraine
- ☐ Ulcer
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Arthritis
- ☐ Back Trouble
- ☐ Heart Murmur
- ☐ Varicose Veins
- ☐ Bleeding Disorder
- ☐ Asthma or Hayfever
- ☐ Nervous Breakdown
- ☐ Chronic Diarrhea
- ☐ Gallbladder Disease
- ☐ Convulsions
- ☐ Skin Disease
- ☐ Blood Clots or Phlebitis
- ☐ High Blood Pressure
- ☐ Blood Transfusions
- ☐ Kidney Stone
- ☐ Auto Immune

Other

ALLERGIES

Please list, if any.

Medication Allergies

Other Allergies

Latex ☐ Yes ☐ No

MEDICATIONS

Check any of the following medications that you are presently taking or have taken in the past year:

- ☐ Cortisone or Steroids
- ☐ Blood Pressure Pills
- ☐ Thyroid
- ☐ Heart Medicine
- ☐ Hormones
- ☐ Sleeping Pills
- ☐ Asthma Medicine
- ☐ Diet Pills
- ☐ Antibiotics
- ☐ Pain Medicine
- ☐ Arthritis Medicine
- ☐ Tranquilizer or Nerve Pills
- ☐ Diuretics (Water Pills)

Other

HOSPITALIZATIONS

If you have ever been hospitalized for any illness or surgery, please list below (excluding childbirth):

YEAR	DIAGNOSIS	HOSPITAL	YEAR	DIAGNOSIS	HOSPITAL

GYNECOLOGICAL HISTORY

Name

Exam Date

Age at first menstrual period

How long since last pap smear?

Date of most recent period

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

Periods occur about every____days

Any past infection of uterus, tubes or ovaries? ☐ Yes ☐ No

and last_____days

Any problem with pelvic pain, other than with periods? ☐ Yes ☐ No

Heavy flow? ☐ Yes ☐ No

Ever lose urine unintentionally? ☐ Yes ☐ No

Severe pain with periods? ☐ Yes ☐ No

Ever have any gynecological surgery? ☐ Yes ☐ No

Any bleeding between periods? ☐ Yes ☐ No

Details

Bleeding after intercourse ☐ Yes ☐ No

OBSTETRIC HISTORY

Previous pregnancies:

Full Term

Living Children

Premature

Any complications of pregnancy, labor or delivery? ☐ Yes ☐ No

Miscarriage

Any Cesarean births? ☐ Yes ☐ No

Voluntary Abortion

List date(s), year(s), location(s):

CONTRACEPTIVE HISTORY

Current method:

Any problems with present or past methods? ☐ Yes ☐ No

Prior methods:

PERSONAL INFORMATION

Highest level of schooling

Do you smoke cigarettes? ☐ Yes ☐ No

Do you drink any alcoholic beverages? ☐ Yes ☐ No

SEXUAL HISTORY

Age at first intercourse?

Approximate frequency of sexual intercourse:

Would you describe your sexual experience in general satisfying? ☐ Yes ☐ No

Less than satisfying in any way? ☐ Yes ☐ No

Any pain with intercourse? ☐ Yes ☐ No

OTHER MEDICAL PROBLEMS If you are now, or have been, under the care of a physician for any medical problems not listed or mentioned so far, please list below the doctor's names and the problems for which they have been consulted. Include consultations for accidents or injuries.

Doctor's Name	Problem

	If Living		If Deceased		Has any blood relative ever had	
FAMILY HISTORY	Age	Health	Age at Death	Cause	Please Check:	Who?
Father					☐ Diabetes	
Mother					☐ Tuberculosis	
Brother 1.					☐ Cancer	
or Sister 2.					☐ High Blood Pressure	
3.					☐ Epilepsy	
4.					☐ Hemophilia	
5.					☐ Heart Disease	
Son or 1.					☐ Muscular Dystrophy	
Daughter 2.					☐ Glaucoma	
3.					☐ Down Syndrome	
4.					☐ Birth Defects	
5.					☐ Twins	

Has your mother or a sister had breast cancer? ☐ Yes ☐ No

Did your mother take the drug diethylstilbestrol (DES) to prevent miscarriage when she was pregnant with you? ☐ Yes ☐ No

☐ Physical or sexual abuse, past or present, can create serious physical and emotional problems for women. If this is an issue would you like to discuss, please indicate by clicking in the box

SYSTEMS REVIEW Please check any of the following symptoms that you have now or that have been present during the past six months:

- ☐ Any serious disease of the eyes, ears, nose, throat
- ☐ Loss of consciousness, fainting, seizures
- ☐ Chronic cough
- ☐ Loss or gain or 10 lbs. or more in past six months
- ☐ Nausea or vomiting
- ☐ Rapid or irregular heartbeat
- ☐ Blood or mucus in the stool
- ☐ Breast discharge or change in size
- ☐ Persistent anxiety or depression
- ☐ Lumps in breast
- ☐ Chest pains
- ☐ Diarrhea
- ☐ Shortness of breath
- ☐ Black or tarry stool
- ☐ Hot flashes
- ☐ Joint pain
- ☐ Leg cramps
- ☐ Back pain
- ☐ Accident or injury

Name

Exam Date

Please use this space for comments and/ or additional information.

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

2001 Peachtree Road NE, Suite 435
Atlanta, Georgia 30309

MEDICATION LIST

Name ______________________ Exam Date ____________

Known Allergies

Please list below all medications you take on an ongoing basis, as well as anything you are taking temporarily (like an antibiotic for a bladder infection).

Please include non-prescription medicines (like aspirin, vitamins, or calcium) and any herbal medicines or nutrition supplements.

Medications you are currently taking	Strength (Dosage)	How often taken	Doctor's Comments

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

Breast Cancer Risk Assessment Worksheet

Name ______________________ Exam Date __________

1. What is your ethnicity? ☐ Caucasian ☐ Hispanic ☐ Black ☐ Other

2. How old are you? Years ________

3. How old were you when you had your first period? Years ________

4. How old were you when your first child was born? Years ________

5. Have any of your first-degree relatives (mother, sister, daughter) had breast cancer? ☐ Yes ☐ No

6. How many breast biopsies have you had? ________

7. Did any of the breast biopsies show atypical cells? ☐ Yes ☐ No ☐ Not Sure ☐ N/A

Additional Risk Factors:

1. Do you have a personal history of breast cancer? ☐ Yes ☐ No

If yes, how many? ________

2. Have any of your second-degree relatives (cousin, niece, aunt or grandmother) had breast cancer? ☐ Yes ☐ No

3. Do you or any family member have a BRCA 1 or BRCA 2 gene mutation? ☐ Yes ☐ No ☐ Don't Know

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

John B. Pugh, M.D.

Financial Policy

We are committed to meeting your health care needs with the highest quality of care. In order to keep financial arrangements as simple as possible, we have implemented the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment not honored by your bank may result in a $35.00 returned check charge.

2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3. If you are unable to provide us with current insurance information (i.e., a current insurance card or written documentation of coverage from your insurance carrier), you will be required to pay for any services you receive. When you have provided us with the insurance information, we will file a claim with your insurance carrier and reimburse you once we have received their payment.

4. It is your responsibility to contact your insurance carrier to confirm that our office participates in your plan. If you receive services from our office and we are not on your plan, you will be responsible for payment in full of our fee(s).

5. All co-pays are due at the time of service. A $25.00 service fee may be charged for failure to pay the co-pay at the time of the service.

6. We use Piedmont Hospital, LabCorp or Quest for all laboratory services. If your insurance requires us to use another lab (such as LabOne), it is your responsibility to let us know at the time of the visit.

7. All medical records requests must be submitted in writing and received in our office ten (10) work days prior to the date needed. This request requires your signature and the complete name and address where the records are to be mailed. We will fax five (5) pages or less provided the fax number is provided with your request.

Items 8 and 9 address problems that affect the efficiency of the office and overall patient services. We will be very pleased if we never have an occasion to apply any of these fees.

8. We charge a fee of $50.00 for each appointment missed, cancelled or rescheduled if our office is not contacted 24 hours or more prior to your appointment time. Only with a minimum of 24 hours notice can we make the appointment time available to another patient. **There are no exceptions to this policy; please do not ask.**

9. Due to increasing regulations and insurance requirements, the volume of our administrative paperwork has increased dramatically. These costs cannot be recovered by a fee increase because insurance reimbursement rates are not linked to our fee schedule. Because of this increase in overhead, we can no longer provide specific administrative services free of charge as we have done in the past. We will require a pre-paid $25.00 fee for the completion of forms including, but not limited to: marriage license, foreign travel, family medical leave, disability, life, adoptions, camp, letters or other administrative forms required by parties other than your insurance company, other miscellaneous letters or forms requested.

We will require a pre-paid $25.00 fee for a patient requested computer generated report such as payment history, extra claims, etc.

We will charge a per page fee for any records requested to be sent to the patient.

Additional items not listed here and not covered by insurance will be priced when requested.

____

Signed By

Printed Name

Date

Please Initial

Rev:0609

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

John B. Pugh, M.D.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996
(HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Cheryl E. Crawford
2001 Peachtree Road NE, Suite 435
Atlanta, Georgia 30309
404/355-6600

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children

Please Initial

or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your JIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D**. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks**. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

• Maintaining vital records, such as births and deaths
• Reporting child abuse or neglect
• Preventing or controlling disease, injury or disability
• Notifying individuals if a product or device they may be using has been recalled
• Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
• Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities**. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

• Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
• Concerning a death we believe has resulted from criminal conduct
• Regarding criminal conduct at our offices
• In response to a warrant, summons, court order, subpoena or similar legal process
• To identify/locate a suspect, material witness, fugitive or missing person
• In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. **National Security**. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institutions, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. **Workers' Compensation**. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to Cheryl Crawford, 2001 Peachtree Road NE, Suite 435, Atlanta, Georgia 30309 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Cheryl Crawford, 2001 Peachtree Road NE, Suite 435, Atlanta, Georgia 30309. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Cheryl Crawford, 2001 Peachtree Road NE,

Suite 435, Atlanta, Georgia 30309, in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Cheryl Crawford, 2001 Peachtree Road NE, Suite 435 , Atlanta, Georgia 30309. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created he information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an accounting of disclosures. An accounting of disclosures is **a list of** certain non-routine disclosures our practice has made of your **IIHI for** non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Cheryl Crawford, 2001 Peachtree Road NE, Suite 435 Atlanta, Georgia 30309. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of** this Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Cheryl Crawford at 404/355-6600.

7**. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. **To file a** complaint with our practice, contact Cheryl Crawford, 2001 Peachtree Road NE, Suite 435 , Atlanta, Georgia 30309. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing . After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Cheryl Crawford at 404/355-6600.

Effective Date of this Notice: 3/1/03

Please Initial ______

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

John B. Pugh, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _________________________, have had made available to me a copy of Piedmont Gynecology & Obstetrics, P.C.'s Notice of Privacy Practices.

____
Signature

Printed Name ____________________

Exam Date ____________________

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

John B. Pugh, M.D.

Preventative Screening Questionnaire

Please fill out the following information related to your health.
Check all boxes that apply to you.

Name ____________ Exam Date ____________

Who is your primary care physician? Name ____________

Address ____________ Phone Number ____________

Pneumonia Vaccination (if you are 65 or older):

- ☐ I have received a pneumonia vaccination. Approximate Date
- ☐ I have not received a pneumonia vaccination.
- ☐ I would like information on the pneumonia vaccination.

Tobacco Use (all patients):

- ☐ I currently use tobacco.
- ☐ I currently do not use tobacco.
- ☐ I would like information and assistance quitting.

Colon Cancer Screening (if you are 50 or over):

- ☐ I have been tested for colon cancer (colonoscopy). Approximate Date
- ☐ I have never been tested for colon cancer.
- ☐ I would like information on colon cancer screening.

Breast Cancer (if you are 40 or over):

- ☐ I have had a mammogram in the past two years. Approximate Date
- ☐ I have not had a mammogram in the past two years.
- ☐ I have a family history of breast cancer.
- ☐ I would like information on breast cancer screening.