*SCAN CODE / PATIENT MRN: _____

Peninsula Community Health Services
HEALTH HISTORY QUESTIONNAIRE

NAME: First: _____ MI: ___ Last: _____ **DOB:** ____ / ____ / _____

PRIOR / OUTSIDE CARE

Previous PCP _____ ER / Hospital visit within 12 month? Yes | No

Specialist(s) _____ Reason: _____

ALLERGIES		NAME	REACTION:
NONE ❒	❒ LATEX		
	❒ ANESTHESIA		

MEDICATIONS (Prescriptions, over-the-counter meds, supplements)			
NAME	DOSE / STRENGTH	DIRECTIONS (AMOUNT / FREQUENCY)	REASON FOR USE
**FOR ADDITIONAL PLEASE WRITE ON BACK OF FORM*			

MEDICAL HISTORY (CIRCLE ALL THAT APPLY TO YOU)

Alcohol | Substance Use Disorder	Headaches	Mental Health disorder
Anemia	Hearing concerns	Musculoskeletal concerns
Blood disorder (Clots, bleeding)	Heart disorder (Arrythmia, congenital, CHF, MI / CAD, endocarditis, rheumatic fever)	Osteopenia / Osteoporosis
Blood pressure (High, Low)	High Cholesterol	Seizures / Epilepsy
Cancer (Chemo | Radiation)	Immune disorder (HIV/AIDs, Rheum)	Sleep issues (Insomnia, OSA)
Congenital / Development disorder	Kidney disorder (CKD, stone)	Stroke (CVA / TIA)
Diabetes	Liver (cirrhosis, fatty, hepatitis)	Thyroid disorder
Gastro (GERD, ulcer, polyp)	Lung disease (Asthma, COPD, PE)	Urinary disorder

DENTAL HISTORY

Yes | No Has a health professional recommended antibiotics prior to dental work?

Yes | No Have you ever had a blood transfusion, rheumatic fever, endocarditis, or significant heart disease? (e.g. congenital issues, valve repair/replacement, CABG/stent, pacemaker, etc)

Yes | No Are you taking or plan to take medication for bone thinning (osteopenia / osteoporosis) or skeletal disorders (e.g. Paget's Disease, multiple myeloma, metastatic cancer)?
[e.g. Fosamax (alendronate) or Boniva, Actonel, Aredia, Zometa, Reclast, Prolia]

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SURGICAL HISTORY

PROCEDURE	DATE	GENDER-SPECIFIC	DATE
❒ Appendectomy	____	❒ Breast (Biopsy, Mastectomy)	
❒ Bariatric (Gastric Sleeve, Bypass)	____	❒ Colposcopy / LEEP / Endometrial Biopsy)	
❒ Cholecystectomy (Gallbladder)	____	❒ Hysterectomy / Tubal ligation	
❒ Colon (Polyp, Resection)	____		
❒ ENT surgery (Ear tubes, Tonsillectomy)	____		
❒ Heart (Valve, Bypass, Pacemaker)	____	OB: #Preg___ #Deliveries____ #C-section___ #Vaginal___	
❒ Hernia			
❒ Joint Replacement	____	❒ Circumcision	
❒ Organ Transplant	____	❒ Prostate	
❒ Thyroidectomy	____	❒ Vasectomy	

FAMILY HISTORY (CIRCLE THOSE THAT APPLY TO FAMILY MEMBERS)

CONDITION	CONDITION	CONDITION
Alcohol | Substance Use Disorder	Headaches	Mental Health disorder
Anemia	Hearing concerns	Musculoskeletal concerns
Blood disorder (Clots, bleeding)	Heart (Afib, congenital, CAD, CHF)	Osteopenia / Osteoporosis
Blood pressure (High, Low)	High Cholesterol	Seizures / Epilepsy
Cancer (Chemo | Radiation)	Immune disorder (HIV/AIDs, Rheum)	Sleep issues (Insomnia, OSA)
Congenital / Development disorder	Kidney disorder (CKD, stone)	Stroke (CVA / TIA)
Diabetes	Liver (cirrhosis, fatty, hepatitis)	Thyroid disorder
Gastro (GERD, ulcer, polyp)	Lung disease (Asthma, COPD, PE)	Urinary disorder
Comments:		

SOCIAL HISTORY (HELP US GET TO KNOW YOU BETTER!)

PLACE OF BIRTH: _____ OCCUPATION: _____ HOBBIES: _____

MARITAL STATUS: Single | Long-term dating | Married | Divorced | Widowed # of kids _____ # of pets _____

- DO YOU USE **TOBACCO / NICOTINE PRODUCTS**? ❒ Yes ❒ No ❒ Former
- DO YOU DRINK **ALCOHOL**? ❒ Yes ❒ No ❒ Former
- DO YOU USE **MARIJUANA OR OTHER DRUGS?** ❒ Yes ❒ No ❒ Former

- DO YOU HAVE:
  - **LIVING WILL**? ❒ Yes ❒ No
  - **DURABLE POA?** ❒ Yes ❒ No

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PATIENT REGISTRATION INFORMATION			
Legal Last Name:			Legal First Name:
First Name Used:			Middle Name: Suffix:
Date of Birth: / /	Sex at Birth: M / F		Previous Name:
Legal Sex: M / F	Mother's Maiden Name:		
Address:			City:
State:	Zip:	Patient Email:	
Mobile Phone:		Primary Phone: ☐Yes	Consent to text? ☐Yes ☐No
Home Phone:		Primary Phone: ☐Yes	Consent to call? ☐Yes ☐No
Are you a School-Based Health Patient: ☐Yes ☐No **If YES** which school: _____			How would you like to receive your after-visit summary? ☐Portal ☐Paper
How did you hear about us: ☐Advertising ☐Primary Care Provider ☐ Specialist ☐Word of Mouth ☐Patient in the Practice ☐Hospital ☐Insurance Company ☐Social Media ☐Other _____			
Emergency Contact Information			
Name:			Relationship to Patient:
Home Phone:			Mobile Phone:
Guarantor Information (to whom statements are sent)			
Patient's Relationship to Guarantor:			Address:
Guarantor Name (last, first):			Date of Birth: / /
Home Phone:			Mobile Phone:
PCHS In-House Pharmacy Location			
☐6th Street ☐ Clare Ave. ☐Port Orchard ☐Belfair ☐Poulsbo ☐Key Peninsula ☐ Other If other, Name and location _____			

Primary Insurance		Secondary Insurance	
☐ **I have no insurance, please contact me for options**			
Plan Name:		Plan Name:	
Last Name:		Last Name:	
First Name:	Middle Initial:	First Name:	Middle Initial:
ID#	Group#	ID#	Group#
Address:		Address:	
City, State, Zip:		City, State, Zip:	
DOB: / / Sex: M / F		DOB: / / Sex: M / F	
Relationship to Patient:		Relationship to Patient:	

Insurance Authorization

I accept financial responsibility for all my professional services and/or supplies. Payment for services is due at the time rendered unless arrangements have been made.

I authorize my insurance to pay PCHS directly. I am financially responsible for any balance due. I authorize PCHS or the insurance company to release any information for claims unless specifically limited by me in writing.

Patient/Guardian Signature: _____Date:_____

Lifetime Authorization For Billing Medicare *Medicare Recipients Only*

I request that payment for authorized Medicare benefits be made on behalf of Peninsula Community Health Services for any services provided to me.

Patient/Guardian Signature: _____Date:_____

I acknowledge that I have received a copy of my rights and responsibilities and the PCHS Clinic Policies. Initial: _____

UNIFORM DATA SYSTEMS-PCHS is required to collect the following information from our patients who utilize our services. The following information, when reported, does not include any personal identification information and is confidential.

Marital Status(check one): ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Partner

Language: | **Do you need an Interpreter?** ☐Yes ☐No

Ethnicity (check one): ☐Mexican, Mexican American, or Chicano(a) ☐Puerto Rican ☐Cuban ☐ Another Hispanic, Latino(a), or Spanish origin ☐Not Hispanic/Latino(a) ☐Unreported/Refused

Race (check all that apply): ☐Asian Indian ☐Chinese ☐Filipino(a) ☐Japanese ☐Korean ☐Vietnamese ☐ Other Asian ☐Native Hawaiian ☐ Other Pacific Islander ☐Guamanian or Chamorro(a) ☐Samoan ☐ Black/African American ☐American Indian/Alaskan Native ☐White ☐Unreported/Refused

How many people are in your household? _____	**Check range of your household's annual income:** ☐$0 - $15,060 ☐$26,650.01 - $32,150 ☐$15,060.01 - $21,150 ☐$32,150.01 - $37,650 ☐$21,150.01 - $26,650 ☐$37,651 & Higher
Migrant Worker Status ☐Not a farm worker ☐Migrant ☐Seasonal	***Veterans Status*** ☐Veteran ☐Not a Veteran

Housing Information

☐own/rent your home without help (NOT HOMELESS) ☐ Staying with Friends /Relatives (DOUBLING UP) ☐Have concerns about your housing and want help(OTHER) ☐Living on the street, outdoor, in a car/travel trailer(STREET) ☐Staying in a treatment facility (TRANSITIONAL) ☐Living in public housing where all tenants get discount rent (PUBLIC HOUSING)	☐Staying in a shelter-short term housing like the mission, YMCA, etc (SHELTER) ☐Living Somewhere not meant to be a home-no running water/heat (OTHER) ☐Having been homeless in the last year and have housing now (TRANSITIONAL) ☐ Homebound

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HEALTH INSURANCE PORTABLITY ACCOUNTABILITY ACT (HIPAA), PERSONAL HEALTH INFORMATION (PHI), AND HEALTH INFORMATION EXCHANGE (HIE) / COMMUNITY INFORMATION EXCHANGE (CIE), AND OLYMPIC CONNECT CONSENT

Privacy Notice Acknowledgment

I acknowledge that I have received PCHS's Health Insurance Portability Accountability Act (HIPAA) pamphlet. I have been informed that any questions and/or comments about this notice can be directed to PCHS's Privacy Officer, Jennifer Kreidler-Moss, CEO, at the following address and phone number:

Peninsula Community Health Services PO Box 960 Bremerton, WA 98337 (360) 377-3776

Notice of Privacy Practices

PCHS maintains a record of your healthcare services and will not disclose your record to others unless you tell us to or unless the law requires disclosure. You have the right to request a copy of and to correct your record by contacting PCHS's Health Information Management (HIM) Department: (360) 377-3776

Information Sharing

PCHS is an integrated health system (medical, dental, pharmacy, mental health, substance use disorder, support services). PCHS may share your health information within our own clinic system for continuity of care. To support your care coordination, PCHS may also share patient information with community partners such as social service providers, hospitals, schools, and jails to the extent allowed by law. Where privacy laws limit information sharing, PCHS will not share your information unless you give authorization.

Consent to Participate in Olympic Connect and Health Information Exchange/Community Information Exchange

PCHS participates in Olympic Connect, a Community Care Hub of Washington. This service is provided by Olympic Community of Health in collaboration with local Service Providers who coordinate your care. Olympic Connect connects people to community resources to address social needs. If you choose to participate and receive services, Olympic Connect may collect and use your personal and health information (name, contact, demographic information, health insurance, details about any needs you have, certain health care information, and services you receive) to help provide those services.

PCHS also participates in a Health Information Exchange (HIE) and Community Information Exchange (CIE) to share information about your care with other healthcare and service providers in order coordinate your care and connect you with services.

_____ **YES to Participate:** I consent to disclosing the patient's protected health information to Olympic Connect, HIEs, and CIEs to support care coordination with participating Service Providers.

_____ **NO to Participate:** I DO NOT consent to disclosing the patient's protected health information to Olympic Connect, HIEs, or CIEs to support care coordination with participating Service Providers.

_____ _____ _____

Patient Signature Patient Printed Name Date

_____ _____

(Print) Guardian/Legal Representative Name Relationship to Patient

_____ _____

Guardian/Legal Representative Signature Date

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NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

Peninsula Community Health Services (PCHS) respects every patient. Patient Rights and Responsibilities explain what you can expect from us and what we expect from you.

As a patient, you have the right to:

- Be treated with respect and dignity in a safe and private setting.
- Respect for your cultural, social, spiritual, and personal values and beliefs.
- Take part in your health care and treatment.
- Know the names and professional status of the people caring for you.
- Ask questions and be informed about your illness and treatment, including options for your care and likely outcomes.
- Get another opinion about your care or change your provider.
- Privacy of your health records and the right to permit or refuse the release of information, except when required by law.
- Ask about the wide variety of services available through PCHS.
- Be informed of how to access care when the clinic is closed.
- Know about legal reporting requirements.
- Ask for special arrangements if you have a disability or need an interpreter.
- Receive information about living wills and have the intent of your wishes honored, as allowed by law.
- Consent to treatment, care, and services as allowed by law.
- Refuse treatment, care, and services as allowed by law.
- Know the cost of your care, ways you may pay for care, and ask for financial assistance if you need it.
- Refuse to be included in any research program or study.
- Receive information about ways of expressing comments and complaints.
- Report any issue or concern to the Washington State Department of Health at 1-800-633-6828. If you are a Medicare member and have a concern regarding quality of care, you can also contact Medicare at 1-800-633-4227. Medicare TTY/TTD users can call 1-877-486-2048.

PCHS is a licensed outpatient mental health and substance use disorder treatment agency. State law guarantees that as a patient, you have the right to:

- Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age, or disability.

04/20/2023
Legal/Compliance
PCHS Corporate Compliance / Clinical Practices 2000/2004

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- Practice your religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice.
- Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
- Be treated with respect, dignity, and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises or address risk of harm to the individual or others. “Reasonable” is defined as minimally invasive searches to detect contraband or invasive searches only upon the initial intake process, or if there is reasonable suspicion of possession of contraband, or the presence of other risk that could be used to cause harm to self or others.
- Be free of any sexual harassment.
- Be free of exploitation, including physical and financial exploitation.
- Have all clinical and personal information treated in accord with state and federal confidentiality regulations.
- Participate in the development of your individual service plan and receive a copy of the plan if desired.
- Make a mental health advance directive consistent with Chapter 71.32 RCW.
- Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections.
- Submit a report to the Department of Health when you feel the agency has violated your rights or a requirement regulating behavioral health agencies.

As a patient, you have the responsibility to:

- Share any information that may impact your care with your provider.
- Ask questions when you do not understand information or instructions about your care.
- Inform your provider if symptoms persist or worsen or you have an unexpected reaction to a medication.
- Take medications as prescribed. If taking certain medications, you may be asked to sign and follow a medication agreement.
- Provide insurance information or proof of income and family size when applying for discounts.
- Pay amounts due. Hardship waivers and discounts are available.
- Show respect to both staff, volunteers, and other patients.
- Cancel or reschedule appointments in a timely manner.
- Only use medications or medical devices prescribed for you.
- Voice your concern regarding any part of the care you receive at PCHS. Suggestions and comments are welcome.

04/20/2023
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