Northwestern
Health Sciences University

NURSE PRACTITIONER HEALTH HISTORY FORM

FOR OFFICE USE ONLY:	
__ Bloomington Natural Care Center __ University Health Services	Date: _____ Account Number: _____

Name		Date of birth	

Reason for visit:

_____

_____

Family History – Please note any conditions in your family especially in your parents, siblings, and grandparents.	
Medical Condition	**Family member with this**
☐ No changes since last visit	
Cancer Type:	☐ None
Heart Disease	☐ None
Diabetes	☐ None
High blood pressure	☐ None
High cholesterol	☐ None

Personal History – For each item below, select one choice and provide details when asked.			
Marital History ☐ Single ☐ In a Relationship ☐ Married ☐ Divorced/Separated ☐ Widowed			
Do you feel safe at home? ☐ Y ☐ N			
Sexual Health Do you have sex with: ☐ Men ☐ Women ☐ Both ☐ Neither			
Do you exercise? ☐ Y ☐ N How much? What type?			
Do you use tobacco? ☐ Y ☐ N How much?			
Do you use street drugs? ☐ Y ☐ N ☐ Current use			
Do you use alcohol? ☐ Y ☐ N How much?			How many times in the last year have you had more than 4 drinks in a day? ☐ Once a week ☐ Once a month ☐ A few times a year ☐ Never
Have you ever tried to cut down on your use of alcohol?	☐ Y	☐ N	
Do you get angry if people ask you to stop drinking?	☐ Y	☐ N	
Do you feel guilty about your drinking?	☐ Y	☐ N	
Do you ever drink alcohol shortly after waking up?	☐ Y	☐ N	

Circle any of these you have had within the last 2 weeks or are concerning to you. ☐ Check here if you have had none of these symptoms	**Comments**
fevers, chills, night sweats, fatigue, unintentional weight change	
vision change, double vision, red eyes	
hearing change, sinus pain, throat pain	
chest pain, palpitations, pain with walking	
cough, shortness of breath, wheezing	
nausea, vomiting, diarrhea, constipation, abdominal pain, heartburn	
change in urine, incontinence, sexual dysfunction	
joint pain, muscle pain, swelling	
concerning lesions or moles, rash	
loss of strength or sensation, numbness or tingling, dizziness, headache	
excessive thirst, heat or cold intolerance	
concerning bumps, bleeding problems	
environmental allergies	
depression or anxiety, sleep problems	

Over the past 2 weeks, how often have each of the following bothered you? (Circle one)				
	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Health Care Maintenance – For each measure check only if you have had the test and fill in the date of last test.		
Preventative Measure	**Screening Test**	**Date of last test**
Colon Cancer	☐ Colonoscopy ☐ Sigmoidoscopy ☐ Stool cards	
Breast Cancer (women)	☐ Mammogram	
Cervical Cancer (women)	☐ Pap smear Any Abnormal ☐ Y ☐ N	
Prostate Cancer (men)	☐ PSA Blood Test ☐ Rectal Exam	
Osteoporosis	☐ Bone density (Dexa scan)	
Vaccines	☐ Tetanus Date:_____ ☐ Flu Date:_____ ☐ Pneumococcal Date:_____	

Health Care Maintenance – Females only		
Menstrual Period	Date of last period:	Concerns:
Pregnancy	Number of pregnancies:	Number of live births:

Past Medical and Surgical History		Medications
Date	**Medical Condition or Surgical Procedure**	**List all current medications and dosages**
		Allergies (medications, substances):

My signature indicates that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Signature Relationship to patient Date

Northwestern
Health Sciences University

NURSE PRACTITIONER INFORMED CONSENT FORM

Patient Name	File #	Date

Authorization

I hereby authorize the performance of diagnostic tests, procedures and treatment deemed necessary by my primary care provider. I understand that information about my case may be used in case presentations (my name and other personal information is kept confidential).

I understand that I may stop treatment at any time.

Printed Name _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEATLH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

OUR PRIVACY PLEDGE: The NWHSU-Clinic System is committed to full compliance with federal and state laws and regulations ensuring the privacy and confidentiality of our patients' and clients' personal health information; the clinicians and staff will make every effort to respect your privacy and keep confidential the health information entrusted to us.

Our Duties: We are required by law to maintain the privacy of your health information, to provide you with this notice of our legal duties and our privacy practices, and to abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices in accordance with federal or state law; any such change will apply to all of your information in our files.

University Clinic patients and clients will be asked to consent to the use or disclosure of your protected health information by agreeing to allow University clinicians or support staff members to:

- Use your health information within the University Clinic System, or disclose your health information to another health care provider or facility for the purpose of diagnosis, assessment or treatment of your condition.
- Use your health information within the University Clinic System, or disclose your examination, treatment and billing records to another party, such as an insurance carrier, an HMO or your employer for the purpose of receiving payment for services rendered to you.
- Use your health information, examination, treatment and billing records for quality control or other administrative purposes to efficiently and effectively operate the practice.
- Disclose your health information to business associates that perform services for the University's or your benefit and bill for it. All University business associates are contractually required by us to similarly safeguard the privacy and confidentiality of any personal health information disclosed to them.
- Use that information for research purposes, and then only after the University's Institutional Review Board (IRB) has reviewed and approved the research proposal, and established procedures to ensure maintenance of privacy and confidentiality.
- Use your personal health information to contact you by telephone, mail or e-mail with appointment reminders, NWHSU-Clinic System newsletters, information about treatment alternatives or other health related information that may be of interest to you. If not at home to receive an appointment reminder, a message may be left on your answering machine. We may also contact you for the purpose of providing University fundraising information.

Required or Permitted Uses and Disclosures Without Your Consent: Use or disclosure of your health information without your consent may be required or permitted in some circumstances, including but not limited to: 1) The extent that we are required or permitted to do so by applicable federal or state laws; 2) A public health authority for a wide range of public health activities when authorized to collect or receive your health information under federal or state law; 3) An appropriate government authority if there is reason to believe you are the victim of abuse, neglect or domestic violence; 4) Federal or state health care system and government benefit program oversight activities; 5) A response to a court order, or in response to a subpoena, discovery request or other lawful purpose; 6) Law enforcement officials when required to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena or administrative requests; 7) An appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or the public; 8) A correctional institution if we provide health care services to you as a inmate; 9) Emergent care situations; and 10) Providing care to you that is related to a work-place injury to the extent necessary to comply with Minnesota's worker's compensation laws.

The Health Care Information Rights of Our Patients and Clients Include:

Your Right to Revoke Consent: You may revoke your consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your Right to Limit Uses or Disclosures: You have a right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services we provide at a place other than your home or if you would like the information in a different form.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, the University is not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without your consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purposes; 7) Were made to correctional or law enforcement officers; or 8) Were made prior to April 14, 2003.

We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time or access this notice on the Northwestern Health Sciences University website at www.nwhealth.edu.

Your Right to Complain: You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact the University Compliance/Privacy Officer at:

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR PRIVACY PLEDGE: The Northwestern Health Sciences University (NWHSU) Clinic System is concerned with and committed to the protection of our patients' and clients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the University may use or disclose your health care information include, but are not limited to:

- Another health care provider within the University Clinic System, or to another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- Business associates that we contract with to perform a service for your benefit.
- Research, when the University review board has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, lab or imaging results, information about our clinic facilities, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic facility, on the University web site at www.nwhealth.edu, and will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial here

[ ] I acknowledge receipt of the NWHSU-Notice of Privacy Practices

By signing below, I give consent to the NWHSU-clinicians or staff to disclose my personal health information as noted above.

Printed Name	**Authorized Provider Representative**
Signature	**Date**
Date	