Dear Patient,

Welcome! Marimn Health is recognized as a Patient Centered Medical Home. A Medical Home provides services that are patient-centered. The Medical Home acts as the primary point of care for the patient and the relationship between the patient and his/her family. We are happy to serve you as a new patient. To make your visit with us more pleasant, please complete the registration information. We do require that you bring in the necessary items listed below so we are able to register you in our practice.

All patients must present the following:

- Picture ID
- Current medical/dental insurance eligibility cards, including Medicaid and Medicare

In order to establish eligibility for Indian Health Services, Native American applicants must also present the following:

- Tribal Enrollment Card or Certificate of Indian Blood
- If a descendant, a letter of descendancy from your affiliated tribe or a birth certificate and a copy of parents' tribal information

To establish eligibility for our Sliding Fee Program, please bring a copy of your most recent tax return and documentation of your place of residence.

Patients are responsible to pay in full for services received unless Marimn Health is provided appropriate documentation establishing Indian Health Service and/or the Sliding Fee Program. We expect payment at time of service of any co-pays, deductibles, and co-insurance.

It is important that you provide your signature at the bottom of the first page, the acknowledgement of receipt, and the self-determination sections.

Thank you for your cooperation,

Marimn Health
First Impressions Department

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

Please select the location(s) you are requesting below:

☐Medical ☐Dental ☐Behavioral Health ☐Optical ☐Chiropractic

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____

Date of Birth: ____/____/____ Gender (at birth): ☐Male ☐ Female ☐ Choose Not to Disclose

Social Security # (SSN): _____ Email Address: _____

Home Phone #: _____ Cell Phone #: _____

Notification Preference: Phone Email Text Patient Portal

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Mailing Address:

Address: _____ City: _____ State: _____ Zip: _____

Physical address (*if different from mailing address)*:

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Guarantor Information (*Complete **ONLY** if patient is a minor)*:

Parent/Guardian Name: _____ Relationship: _____ Date of Birth: _____

Phone #:

Insurance Information:

Primary Insurance: _____ Policy ID #: _____ Group#: _____

Name of Policy Holder: _____ DOB: / / Policy Holder SSN #: _____

Secondary Insurance: _____ Policy ID #: _____ Group#: _____

Name of Policy Holder: _____ DOB: / / Policy Holder SSN #: _____

*IF YOU HAVE INSURANCE COVERAGE, IT MUST BE BILLED BEFORE INDIAN HEALTH FUNDS ARE APPLIED. AS A COURTESY, WE WILL BILL YOUR INSURANCE FOR SERVICES RENDERED AT MARIMN HEALTH. THE PATIENT OR LEGAL GUARDIAN IS RESPONSIBLE FOR PAYMENT OF ALL SERVICES NOT COVERED BY INDIAN HEALTH OR BY YOUR INSURANCE.

*I AUTHORIZE MARIMN HEALTH TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICAN AND CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. STATEMENTS MAY BE SENT AS A COURTESY BUT PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE. PAYMENT IN FULL MAY BE DEMANDED AT ANY TIME.

*I REQUEST AND CONSENT TO TREATMENT AT MARIMN HEALTH, INCLUDING MEDICAL, DENTAL, COUNSELING, SUBSTANCE ABUSE, PHARMACY, AND ANY OTHER SERVICE OFFERED AT THE CLINIC OR WELLNESS CENTER. THIS FACILITY PROVIDES COMPREHENSIVE AND INTEGRATED HEALTH AND WELLNESS SERVICES AND USES A SHARED MEDICAL RECORD. FURTHERMORE, I AUTHORIZE MY PROVIDER AND ANY OTHER PROVIDER WHO MAY ATTEND TO ME, THEIR ASSISTANTS, NURSES, AND ANY OTHER IN-HOUSE STAFF TO PROVIDE THE SERVICES DEEMED NECESSARY BY MY PROVIDER.
*IN CONSENTING TO TREATMENT, I UNDERSTAND THAT RESULTS OF MEDICAL TREATMENT VARY AND I HAVE NOT BEEN GUARANTEED SPECIFIC RESULT

SIGNATURE: _____ Date: _____

Front Desk Staff Only: MR #: _____ Staff Initials: _____

Patient Name: _____
DOB: _____

MARIMN HEALTH
COEUR D'ALENE TRIBE

The following information helps Marimn Health with funding from several grant sources which better enables us to provide quality care within our communities. We would greatly appreciate it if you would take the time to complete the information requested.

Homeless Status: □ Doubling Up □ Not Homeless □ Shelter □ Street □ Transitional □ Unknown/Unreported
Migrant Worker Status: □ Migrant □ Not a Farmworker □ Not a Migrant Worker □ Seasonal
Language Barrier: □ Yes □ No
Race: □ American Indian □Caucasian □Asian □African American □ Other_____
Veteran: □ Yes □ No
I Consider Myself Primarily: □Hispanic □Non-Hispanic □Other □Decline to Specify
Are you a member or descendant of a Federally Recognized Tribe? □ Yes □ No Tribe Name: _____
****To establish eligibility for Indian Health Services, Native American applicants **must** also present the following:*

- *Tribal Enrollment Card or Certificate of Indian Blood*
- *If a descendant; a letter of descendancy from your affiliated tribe or a birth certificate and a copy of parents' tribal information*

Gender Identity:

□Female □Male □ Female-to-Male □Male-to-Female □Choose Not to Disclose □Other: _____

Sexual Orientation:

□ Straight □ Gay □ Bisexual □Choose Not to Disclose □ Other_____

Pronouns (ex. she, them, he, they, etc.): _____

Please circle the answer that best describes you and your family.

Family Size: 1 2 3 4 5 6 7 8 Other: _____

Family Income: Under $13,000 $13,000-$20,000 $20,000-$30,000

$30,000-$40,000 $40,000-$50,000 $50,000-$60,000

$60,000-$70,000 $70,000-$80,000 Over $80,000

The patient Self-Determination Act is a law passed in 1990. It states that clinics that get Medicare or Medicaid funding are required to offer patients information on the Advanced Directive, such as a living will or durable power of attorney, and we are required to ask if a patient already has an Advanced Directive in place.

□ I do □ I don't currently have an Advanced Directive in place.

If you would like more information on Advanced Directive, please ask your provider for an information packet.

SIGNATURE: _____Date: _____

Front Desk Staff Only: **MR #:** _____**Staff Initials:** _____

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW THIS NOTICE CAREFULLY**.

This Notice:

- Describes your rights and our responsibilities regarding your health information.
- Explains how we may use and share your health information.
- Informs you about special protections required by law.
- Tells you how any updates to this Notice will be communicated.

Who will follow this Notice:

This Notice applies to all staff, healthcare providers, volunteers, students, and departments of Marimn Health, as well as affiliated entities and business associates who assist with your care or healthcare operations.

OCHIN Organized Health Care Arrangement:

Marimn Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Marimn Health, OCHIN supplies information technology and related services to Marimn Health and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Marimn Health with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Uses and disclosures permitted without your authorization:

- **Treatment** – We may use or disclose your health information to provide, coordinate, or manage your healthcare.
- **Payment** – We may use or disclose your health information to obtain payment for services provided to you.
- **Operations** – We may use or disclose your health information for certain activities that are necessary for health care operations.

Other Uses or Disclosures:

- **Appointment Reminders and Treatment Alternatives:** We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services.
- **Business Associates** – We may disclose your health information to business associates with whom we contract to provide services.
- **Coroners, Medical Examiners and Funeral Directors** – We may disclose health information to a coroner, medical examiner or funeral director to assist them in carrying out their duties.
- **Health Oversight:** We may disclose health information to a health oversight agency or public health authority authorized by law to investigate or oversee health provider conduct or conditions.

MRN: _____

- **Idaho Health Data Exchange (IHDE)** – Marimn Health shares information through the IHDE for treatment, payment, and healthcare operations. To opt out, contact IHDE directly at https://idahohde.org/patients/faqs/.
- **Incidental Uses and Disclosure**s – There are certain uses or disclosures of your information that may occur while we are providing service to you or conducting our business.
- **Interpreters:** We may use the services of an interpreter that may require use or disclosure of your personal health information.
- **Law Enforcement** – We may share information with law enforcement to report injuries, prevent serious threats, locate individuals, support national security, or respond to crimes or emergencies.
- **Legal Proceedings** – We may disclose health information to attorneys or courts in response to a subpoena, discovery request or other lawful process.
- **Military** – If you are a member of the armed forces, we may disclose information about you as required by military command authorities or to the Department of Veterans Affairs.
- **Organ Procurement Organizations** – We may disclose health information to organizations that handle organ, eye or tissue donation or transplantation.
- **Public Health Activities:** We may disclose your health information with authorized public health or other governmental authorities authorized by law to receive information for the purpose of preventing or controlling disease, injury, disability, neglect or abuse, or for purposes related to the quality, safety or effectiveness of regulated products or services.
- **Required by Law -** We may use or disclose your protected health information to the extent the law requires it including Worker's Compensation.
- **Research** – We may use or disclose information about you for research projects. Research projects must go through a special process that protects the confidentiality of your information.

Uses and Disclosures When You Have the Opportunity to Object:

- **Disclosure and Notification of Family, Friends or Others Involved in Your Care** – Unless you object, we may share your health information with a family member, caregiver, or other person involved in your care or payment.
- **Disclosure for Disaster Relief Purposes** – We may share your location and condition with authorized disaster relief agencies unless it is health information that requires your written permission, unless required by law.
- **Fundraising** – We may disclose health information to a business associate or Marimn Health-related foundation for the purpose of raising funds for the organization. They will, however, provide you with information about how you can opt out of future fundraising communication.

Uses and Disclosures Requiring Your Authorization: "Opportunity to Object" does NOT apply for these disclosures and a separate written patient authorization is needed:

- **Psychotherapy Notes**: Psychotherapy notes have special protections under federal law, specifically under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at **45 CFR § 164.508(a)(2)**. We generally need your written permission to share them, unless allowed by law for purposes such as your treatment, internal training, legal defense, investigations, required reporting, safety threats, or with medical examiners.
- **Substance Use Disorder (SUD) Treatment Records:** Health Federal law (42 CFR Part 2) protects SUD treatment records. We cannot share this information without your written consent, except in limited cases like emergencies, audits, abuse reporting, or court orders. Even with your presence, we need your consent to share with family or others involved in your care.
- **Reproductive Health Information**: Under the HIPAA Privacy Rule Final Update 2024, we will not disclose information about contraception, fertility, pregnancy, or abortion care without your written consent, except as required by law. You have the right to control how this information is shared.

Patient Name: _____
DOB: _____

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Special Information Types:

- **Genetic Information**: Under the Genetic Information Nondiscrimination Act (GINA), we must obtain your specific written authorization before using or disclosing your genetic information, unless permitted by law (such as for treatment, payment, or healthcare operations).
- **Sexually Transmitted Diseases and HIV/AIDS Information**: We generally need your written permission to release STD-related information (including HIV/AIDS), unless required by law for treatment or public health reporting.
- **Minor's Health Information**: Parental consent is often required to access or share a minor's health information, but this may vary based on the minor's age and type of care (e.g., reproductive or substance use services).

Your Rights: You have the following rights regarding your health information. To exercise these rights, submit a written request:

- **Request a copy of medical records**: You may request your records in paper or electronic form, subject to limited exceptions.
- **Request an amendment**: You may request corrections or amendments to your health information, and we will respond within 60 days. The request must clearly state the reason you believe the amendment or correction is necessary.
- **Request an accounting of disclosures**: You may receive an accounting of certain disclosures we have made of your protected health information, free of charge, within a 12-month period.
- **Request restrictions**: You can ask us not to use or share certain information for treatment, payment, or operations. We are not required to agree unless you paid in full for a service and ask us not to tell your insurer.
- **Request nondisclosure to health plans for self-paid items or services** - If you pay for a service or item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or operations with your health insurer. We will accommodate reasonable requests but may require that you explain how payment will be handled if an alternative means of communication is used.
- **Request confidential communication** - You may ask us to contact you by alternative means or locations.
- **Choose someone to act for you** - You have the right to appoint someone to make healthcare decisions for you or to act on your behalf regarding your health information.
- **Paper copy of notice** - You may request a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically.
- **Notice of Breach -** If a breach of your unsecured health information occurs, we will notify you promptly, as required by law.
- **Changes to This Notice:** We may change this notice and apply changes to all your information. Updated notices will be available in our offices and online.

Complaints: You may file a formal complaint or if you have questions or concerns about your privacy rights. We will not retaliate against you for filing a complaint:

- **Marimn Health Privacy Information Manager:**
- Phone: (208) 686-1931 ext. 1149
- Email: Compliance@marimnhealth.org
- Mailing Address: 427 12th St, Plummer, ID 83851
- **Office of Civil Rights (OCR):**
- Online: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- Email: OCRComplaint@hhs.gov
- Mail: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201.

PATIENT ACKNOWLEDGEMENT OF RECEIPT:

I, _____, hereby acknowledge that I have read and understand this Notice of Privacy Practices.

SIGNATURE: _____ **Date:** _____

MRN: _____

Date Revised: 07/14/2025

Date Approved: 07/14/2025

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

HIPAA Compliance Patient Consent Form

Patient Name: _____

Date of Birth: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Marmin Health reserves the right to change the privacy policy as allowed by law.
- Marimn Health has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Marimn Health may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? _____YES _____NO
May we leave a message on your answering machine at home or on your cell phone? _____YES_____NO
May we discuss your medical condition with any member of your family? _____YES _____NO
If YES, please name the members allowed:

1._____

2._____

3._____

Information to be disclosed:

☐ Medical Records
☐ Labs/X-rays
☐ Other: _____

_____

Consent Signed by:(printed): _____

Signature: _____ Date: _____

Front Desk Staff Only: **MR #:** _____ **Staff Initials:** _____

Authorization for Release of Medical Records

MARIMN HEALTH
COEUR D'ALENE TRIBE

Patient Information:

Patient Full Name: _____ D.O.B. _____ Phone#_____

Information to be released from	Information to be sent/released to:
Name of Facility:	Name of Facility:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone/Fax Numbers:	Phone/Fax Numbers:

*IF RECORDS ARE MORE THAN 50 PAGES, DO NOT FAX. PLEASE MAIL TO: PO BOX 388, PLUMMER, ID 83851

Information to be released: (PLEASE SELECT ONE):

☐ The most recent 2 years of pertinent information (Chart notes, labs, x-rays, and special tests)
(Records from Marimn Health will only be released. We will not release any records from an outside facility.)

☐ Immunizations

☐ Specific Information (Please specify): _____

Purpose for which disclosure is being made: (Please check one of the following)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drugs and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
***EXCLUDE** the following information from the records released (Please initial):

_____Drug/Alcohol Abuse/Treatment and Diagnosis _____ Sexually Transmitted Disease

_____HIV/AIDS Diagnosis/Treatment/Testing _____ Mental Illness or Psychiatric Diagnosis/Treatment

My Rights:
I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. (To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. No charge for medical records released directly to provider/ facility for continued care. There may be a copying fee for medical records released directly to the patient.

For personal requests of records, I prefer to have copies of my records given to me: ☐ electronically OR ☐ paper

Signature:_____**Print Name**: _____**Date**: _____
If Minor, Select one: ☐ Parent or ☐ Guardian

Marimn Health Representative: _____**Date:** _____ **MRN:** _____

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington DC, 20250-9410 or call (702) 720-5964 (voice and TDD).
This authorization will expire 90 days from the date signed unless otherwise specified.

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

Comprehensive Patient History Form

Name: _____ MRN_____ Date: _____

Main Reason For Visit:

_____

_____

Other Concerns:

_____

_____

_____

Please list healthcare providers & their specialty you see regularly:

_____

_____

_____

List any medical supplies you use (e.g. oxygen, wheelchair):

_____

_____

Medication List: ☐ Check if you do not take any prescription or over the counter medications.

***Please note, medications will be reviewed at your Establish Care Visit prior to prescribing or refilling medications. ***

Medication	Dose	Directions
Controlled Substances (i.e. Hydrocodone, Oxycodone, Xanax, Adderall, suboxone, etc)	Dose	Directions

MARIMNHEALTH
COEUR D'ALENE TRIBE

Patient Name: _____
DOB: _____

Allergies or reactions:

Allergy	Reaction (e.g. swelling, rash, stomach problem, breathing difficulty)

Preferred Pharmacy: _____

Preventative Care:

Date of last Colon and Rectal Screening: _____ Result if known: Normal or Abnormal

Date of last eye exam: _____ Date of last dental exam: _____

Past Medical History: (*Check all that apply.)*

- ☐ Acid Reflux
- ☐ Alcohol/Drug Abuse
- ☐ Allergy Problems
- ☐ Anemia
- ☐ Anxiety
- ☐ Artery/Vein Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Crohn's
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Esophagitis
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Thyroid Issues
- ☐ Heart Disease
- ☐ Heart Valve Problem
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/Hep
- ☐ Lung Disease
- ☐ Migraines
- ☐ Mental Health Diagnosis
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent Skin Infection
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually Transmitted Infect.
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB

Other diseases not listed above: _____

Hospitalizations/Significant Injuries: _____

_____

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Patient Name: _____
DOB: _____

Surgery/Procedures History: *(Check all that apply)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Blood Vessel Surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Colon/Rectal Surgery
- ☐ Dental Surgery
- ☐ Eye Surgery
- ☐ Gallbladder
- ☐ Hernia
- ☐ Heart Surgery
  - ☐ Bypass
  - ☐ Heart Valve
  - ☐ Angioplasty
  - ☐ Stents
  - ☐ Pacemaker
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial
- ☐ Joint replacement/Orthopedic surgery
- ☐ Kidney Surgery
- ☐ Organ Transplant
- ☐ Prostate Surgery
- ☐ Thyroidectomy
- ☐ Sinus Surgery
- ☐ Tonsils and/or Adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

Other Surgery not listed above: _____

☐ Previous reaction to anesthesia (explain): _____
_____

Family History:

Adopted: ☐ Yes ☐ No Skip family history if yes and unknown.

Family Member	Age(s)	Living	Cause of Death
Father			
Mother			
Brother(s) #			
Sister(s) #			

Diseases in the family: *(check all that apply)*

- ☐ Arthritis
- ☐ Addiction Problems
- ☐ Bleeding Problems
- ☐ Cancer: Who?
  - ☐ Breast:_____
  - ☐ Colon:_____
  - ☐ Prostate:_____
  - ☐ Other:_____
- ☐ Depression/Anxiety
- ☐ Diabetes:_____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness

For our FEMALE patients only:

Date of last menstrual period: _____
Do you have a Gynecologist ☐ Yes ☐ No If yes, Gynecologist name: _____
Date of last PAP test:_____ Date of last mammogram: _____
Have you gone through menopause ☐ Yes ☐ No
Menstrual problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____
Number of pregnancies: ____ Number of live births:___ Number of abortions: ____
Current birth control method: _____
Have you had a bone density (DEXA) exam? YES NO Date: _____