

**Patient's Name** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

*Please check **only persistent/on-going symptoms** and explain how long you have had symptoms.*

**Constitutional**

- Fatigue \_\_\_\_\_
- Fever \_\_\_\_\_
- Victim/domestic violence \_\_\_\_\_
- Weight gain (unintentional) \_\_\_\_\_
- Weight loss (unintentional) \_\_\_\_\_

**Ears/Nose/Throat**

- Sore throat \_\_\_\_\_

**Cardiovascular**

- Varicose veins \_\_\_\_\_

**Respiratory**

- Wheezing \_\_\_\_\_

**Gastrointestinal**

- Abdominal pain \_\_\_\_\_
- New lack of appetite \_\_\_\_\_
- Bloating \_\_\_\_\_
- Bloody/bright red bleeding in stools \_\_\_\_\_
- Constipation \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Heartburn \_\_\_\_\_
- Acid reflux \_\_\_\_\_
- Hemorrhoids \_\_\_\_\_
- Uncontrollable loss of stool \_\_\_\_\_
- Nausea \_\_\_\_\_
- Vomiting \_\_\_\_\_
- Change in stool size \_\_\_\_\_

**Neurological**

- Headaches \_\_\_\_\_
- Seizures \_\_\_\_\_

**Hematologic/Lymphatic**

- History of blood transfusion \_\_\_\_\_
- Leg/lung blood clots in veins (history of) \_\_\_\_\_
- Leg/lung blood clots in veins (current) \_\_\_\_\_

**Psychiatric**

- Crying spells \_\_\_\_\_
- Depression \_\_\_\_\_
- Sadness \_\_\_\_\_
- Recreational drug use \_\_\_\_\_
- Sleep disturbance \_\_\_\_\_
- Suicidal thoughts \_\_\_\_\_

**Genitourinary**

- Painful periods \_\_\_\_\_
- Pain with sex \_\_\_\_\_
- Pain with urination \_\_\_\_\_
- Sores on vulvar/bottom area \_\_\_\_\_
- Bloody urine \_\_\_\_\_
- Multiple partners in lifetime \_\_\_\_\_
- Frequent bladder infections \_\_\_\_\_
- Recurrent vaginal infections \_\_\_\_\_
- Incomplete bladder emptying \_\_\_\_\_
- Irregular menstrual cycle \_\_\_\_\_
- Heavy periods \_\_\_\_\_
- Lack of periods \_\_\_\_\_
- Bleeding after or with sex \_\_\_\_\_
- Post-menopausal bleeding \_\_\_\_\_
- Frequent nighttime urination \_\_\_\_\_
- Uncontrollable loss of urine \_\_\_\_\_
- vaginal discharge \_\_\_\_\_
- vaginal itching \_\_\_\_\_
- sexual abuse/rape (history of) \_\_\_\_\_
- sexual abuse/rape (current) \_\_\_\_\_

**Integumentary/Breast**

- unusual, irritated, or changing mole(s) \_\_\_\_\_
- breast mass \_\_\_\_\_
- breast skin changes \_\_\_\_\_
- breast tenderness \_\_\_\_\_
- nipple discharge \_\_\_\_\_
- Self-breast exams? Yes \_\_\_\_\_ No \_\_\_\_\_

**Endocrine**

- hair loss \_\_\_\_\_
- heat/cold intolerance \_\_\_\_\_
- new excessive hair growth \_\_\_\_\_
- hot flashes \_\_\_\_\_
- mood swings \_\_\_\_\_
- night sweats \_\_\_\_\_
- PMS \_\_\_\_\_

# Gynecology patient History Questionnaire

The answers to this form will help your provider understand your medical concerns and conditions.

**Name:** \_\_\_\_\_ **Age (years):** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

Referred by: \_\_\_\_\_

Are you here for:  Annual Exam?  Problem?

Please describe your problem if any: \_\_\_\_\_

• **Please list below all the changes that have occurred since you were last seen here:**

Medication:  No changes  \_\_\_\_\_

Pharmacies:  No changes  \_\_\_\_\_

Other Physicians:  No changes  \_\_\_\_\_

Surgeries/hospitalization:  No changes  \_\_\_\_\_

Medical problems:  No changes  \_\_\_\_\_

Family diseases (mother, father, siblings, children):  No changes  \_\_\_\_\_

• **Gynecology**

Monthly periods?  Yes  No Time from start of one to start of next: \_\_\_\_\_

Last normal menstrual period: \_\_\_\_\_ Total number of days bleeding: \_\_\_\_\_

Number of heavy days: \_\_\_\_\_ Average tampon/pad (*circle one or both*) use on a normal day: \_\_\_\_\_

Are you currently sexually active?  Yes  No Do you have a new partner?  Yes  No

Current partner for how long? \_\_\_\_\_

Would you like testing for sexually transmitted diseases?  Yes  No

*Current contraception:*  Condom  Diaphragm  IUD  Patch  Pill  NuvaRing  
 Natural Family Planning  Vasectomy  Tubal  Other: \_\_\_\_\_

• **Social**

Occupation: \_\_\_\_\_ Number of children: \_\_\_\_\_

Marital Status:  single  married  separated  divorced  widow  living together

Do you exercise regularly?  Yes  No Routine: \_\_\_\_\_

Type of exercise: \_\_\_\_\_

• **Vaccines**

Yes  No Are you up-to-date with your tetanus/diphtheria/acellular pertussis (whooping cough) vaccine?  
When? \_\_\_\_\_

Yes  No Are you up-to-date with Gardasil/HPV vaccine? (patients age 9 to 26 years)

Yes  No Are you up-to-date with the flu-shot?

Yes  No Have you had the shingles vaccine? When?

Yes  No Have you had Prevnar 13 for pneumonia prevention? When?

Yes  No Have you had Pneumovax? When? \_\_\_\_\_

Yes  No Do you want any vaccine(s) today? Which ones? \_\_\_\_\_

# Gynecology patient History Questionnaire

Patient's Name \_\_\_\_\_

## • Tobacco/Alcohol/Diet

Have you ever used tobacco products?  Yes  No Quit date: \_\_\_\_\_  
Current tobacco users: packs per day: \_\_\_\_\_ Are you interested in quitting?  Yes  No  
Use of alcohol  Never  Rarely  Frequently  Amount \_\_\_\_\_  
Is your use of alcohol a concern for you or others?  Yes  No  
Do you drink caffeine beverages?  Yes  No  coffee  tea  soda  other: \_\_\_\_\_  
How many cups or bottles a day? \_\_\_\_\_ cups \_\_\_\_\_ bottles  
Are you currently dieting?  Yes  No Which diet? \_\_\_\_\_

## • Other Health Concerns

Are you in a stable relationship?  Yes  No \_\_\_\_\_  
Does your partner mistreat you or the kids?  Yes  No \_\_\_\_\_  
Any family violence?  Yes  No \_\_\_\_\_  
Have you been threatened or hurt by anyone?  Yes  No \_\_\_\_\_  
Your current sexual partner(s) is/are:  male  female  none  
Do you take calcium supplementation?  Yes  No How much a day? \_\_\_\_\_  
Do you eat/drink dairy products regularly?  Yes  No How much a day? \_\_\_\_\_  
Have you traveled outside the USA recently?  Yes  No \_\_\_\_\_  
Do you use tanning beds regularly?  Yes  No \_\_\_\_\_  
Are you happy with your weight?  Yes  No \_\_\_\_\_  
Are you under a lot of stress lately?  Yes  No Why? \_\_\_\_\_  
Do you have a Living Will/Medical Directive?  Yes  No \_\_\_\_\_  
**Any other issues you want to discuss today?** \_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

## **FOR NURSES ONLY:**

BP: \_\_\_\_\_ Weight: \_\_\_\_\_ (prior) \_\_\_\_\_ Height: \_\_\_\_\_ (prior) \_\_\_\_\_ G \_\_\_ P \_\_\_

LMP: \_\_\_\_\_ Paps: \_\_\_\_\_ Abnormal Pap:  Yes  No

Other: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Mail Order:  Yes  No Needs Script: \_\_\_\_\_

	Dates			Comments
Last pap smear	_____	Normal	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Last mammogram	_____	Normal	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Last bone scan	_____	Normal	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Last cholesterol	_____	Normal	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Last colonoscopy	_____	Normal	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

# PATIENT INFORMATION SHEET

Patient Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Primary \_\_\_\_\_ Other \_\_\_\_\_ Work \_\_\_\_\_

DOB \_\_\_\_\_ Social Security # \_\_\_\_\_ Email \_\_\_\_\_

Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

**GUARANTOR OF INSURANCE** \_\_\_\_\_ Date of Birth \_\_\_\_\_

**GUARANTOR EMPLOYER** \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## ALTERNATE CONTACTS (\*\*MUST HAVE AT LEAST ONE\*\*)

Name \_\_\_\_\_ Name \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

## PHYSICIAN CONTACT INFORMATION

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

## PHARMACY INFORMATION

Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### **Assignment of Benefits – Financial Agreement**

I hereby give lifetime authorization of payment of insurance benefits to be made directly to The Women's Clinic, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I authorize The Women's Clinic to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account owed. I authorize The Women's Clinic and its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due. I further agree that a photocopy of this agreement shall be as valid as the original. My signature below indicates that I have read this disclosure and agree to the terms herein described.

Signature \_\_\_\_\_ Date \_\_\_\_\_

August 19, 2015