Total Women's Health and Wellness Center

PATIENT INFORMATION

Date		Patient Number			
Last Name	First Name	MI	Date of Birth	Age	
Street Address	Apartment #	Social Security #			
City	State	ZIP			
Race	Ethnicity	Religion	Language	Marital Status ☐ Single ☐ Divorced ☐ Partner ☐ Married ☐ Separated ☐ Widowed	
Preferred Name	Current Gender Identity ☐ Male ☐ Female ☐ Trans male/Transman/FTM ☐ Decline to State ☐ Trans female/Transwoman/MTF ☐ Different Identity: Please State ______				
Sex Assigned at Birth ☐ Male ☐ Female ☐ Other	Pronouns ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Hir ☐ Otherwise not Listed	Gender on Insurance Plan ☐ Male ☐ Female			
Employment ☐ Retired ☐ Full ☐ Part ☐ None Student: ☐ Full-time ☐ Part-time	Employer/School Name	Job Title			
Spouse's Name	Social Security #	Date of Birth	Work Telephone	Job Title	
Spouse's Employer					

INSURANCE INFORMATION

Primary Insurance Co. Name	ID#	Insured's Employer	**Group #**
Name of Policyholder	Date of Birth	Social Security #	Relationship to Patient
Secondary Insurance Co. Name	ID#	Insured's Employer	**Group #**
Name of Policyholder	Date of Birth	Social Security #	Relationship to Patient

OTHER INFORMATION

Please List Any Allergies		
Preferred Pharmacy		Phone Number
In Case of Emergency Call:	Relationship to Patient	Telephone
Primary Care Physician		PCP's Telephone

How did you hear about our practice? ☐ Friend ☐ Website ☐ Outside Sign ☐ Other: ______

Authorization to Release Information

I hereby authorize Total Women's Health and Wellness Center to release any medical information necessary to process insurance claims and certify that the above information is correct.

Signed (Patient) ______

Authorization to Pay Benefits

I hereby authorize and assign direct payment to Total Women's Health and Wellness Center of surgical and medical benefits. I understand that I am financially responsible for charges not covered by this assignment.

Signed (Patient or Responsible person) ______

Home: ______ **Cell:** ______

Work: ______ **Email:** ______

Name:____________________ Date:____________________

Name of your PCP:____________________ Referred by: ____________________

Reason for visit: ☐ Annual ☐ Problem ____________________

Allergies to medications ☐ Yes ☐ No If Yes, to what medicine? ____________________

Present Medications: ____________________

Would you like Screening for Sexually Transmitted Diseases Today? ☐ Yes ☐ No

Would you accept a Blood Transfusion in life saving circumstances? ☐ Yes ☐ No

Have you had the following Immunizations? ☐ HPV ☐ Rubella ☐ Hepatitis B ☐ Flu (this year?) ☐ Tetanus/Pertussis (TDap) when_____

Last Period: ___/___/___ ☐ Never

Last Pap Smear: ___/___/___ ☐ Never

Last Mammogram: ___/___/___ ☐ Never

Last Colonoscopy: ___/___/___ ☐ Never

Last Bone Density: ___/___/___ ☐ Never

# of Pregnancies ____

# of Vaginal deliveries ____

# of miscarriages ____

# of Children ____ # of adopted children____

# of C-section deliveries ____

# of Abortions ____ # of Ectopics ____

GYN History

Are your periods regular, once a month? ☐ Yes ☐ No

Do you have excessive cramping with your periods? ☐ Yes ☐ No

Do you have bleeding in between your periods? ☐ Yes ☐ No

Do you have excessively heavy periods? ☐ Yes ☐ No

Do you want to do something about your heavy periods? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Do you have leakage of urine? ☐ Yes ☐ No

Do you have an over active bladder? ☐ Yes ☐ No

Do you have a history of:

Fibroids? ☐ Yes ☐ No Ovarian Cysts? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No Breast Disease? ☐ Yes ☐ No

Have you ever been sexually active? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No

New sexual partner in the last year? ☐ Yes ☐ No

More than one partner in the last year? ☐ Yes ☐ No

How long have you been with your current partner? ____

Is your sexual partner ☐ Male or ☐ Female

Current contraception: ☐ None ☐ Condoms

☐ Pills ☐ Patch ☐ Vaginal Ring ☐ IUD

☐ Depo-provera ☐ Implanon ☐ Diaphragm

☐ Tubal Ligation ☐ Vasectomy

Are Finished having children? ☐ Yes ☐ No

Have you been treated for:

Bacterial Vaginal infection/ BV ☐ Yes ☐ No

Trichomonas ☐ Yes ☐ No

Genital Warts (HPV) ☐ Yes ☐ No

Gonorrhea ☐ Yes ☐ No

Chlamydia ☐ Yes ☐ No

Syphilis ☐ Yes ☐ No

Herpes ☐ Yes ☐ No

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

If Yes, when ________ What treatment did you have?____________

Has it been more than 7 years since your last pap? ☐ Yes ☐ No

Did you begin sexual activity before age 16 yrs. old? ☐ Yes ☐ No

Have you had more than 5 lifetime partners? ☐ Yes ☐ No

Have you ever been diagnosed with HIV? ☐ Yes ☐ No

Did your mother take DES while pregnant with you? ☐ Yes ☐ No

Your Medical History:

Hypertension ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Heart Trouble ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid Problems ☐ Yes ☐ No Type:__________

Asthma ☐ Yes ☐ No

Kidney Stones ☐ Yes ☐ No

Blood Clots/DVT ☐ Yes ☐ No

Migraines ☐ Yes ☐ No

~~Heartburn ☐ Yes ☐ No~~

Anemia ☐ Yes ☐ No

Seizures/Epilepsy ☐ Yes ☐ No

Bowel Problems ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

~~Osteopenia ☐ Yes ☐ No~~

Autoimmune Disease ☐ Yes ☐ No

Type:____________________

Cancer ☐ Yes ☐ No

Type:____________________

Other Medical Problems:

____

Surgeries:

	What Year		What Year		What Year		
C-Section ☐	______	Uterine Fibroid Removal ☐	______	Tubal Ligation ☐	______	Gallbladder	☐
Hysterectomy ☐	______	Uterine Ablation ☐	______	Bladder/Prolapse ☐	______	Breast: biopsy	☐
Laparoscopy ☐	______	Fibroid Embolization (UFE) ☐	______	LEEP/ Cone ☐	______	reduction	☐
Hysteroscopy ☐	______	Ovarian Surgery ☐	______	Appendectomy ☐	______	augmentation	☐

Other Surgeries:____________________

Family History:

		Who				Who
Breast Cancer	☐	______		Diabetes	☐	______
Ovarian Cancer	☐	______		Hypertension	☐	______
Uterine Cancer	☐	______		Osteoporosis	☐	______
Colon Cancer	☐	______	☐ before age 50			
Heart Attack	☐	______	☐ before age 50	Blood Clots/DVT	☐	______
Stroke	☐	______	☐ before age 50	Other	☐	______
High Cholesterol	☐	______		NONE	☐	

Social History:

Do you Smoke?	☐ Yes	☐ No	Do you exercise regularly?	☐ Yes	☐ No
Do you drink Alcohol?	☐ Yes	☐ No	Do you eat a diet high in Fat/Sugar?	☐ Yes	☐ No
Avg. # drinks per day?________	#per week______		Do you wear a seat belt?	☐ Yes	☐ No
Do you use recreational drugs?	☐ Yes	☐ No	Do you feel safe in your home/relationship?	☐ Yes	☐ No

Review of Systems:

	Now	Past Year		Now	Past Year
General:			**Musculoskeletal:**		
Weight Loss	☐	☐	Muscle weakness	☐	☐
Weight Gain	☐	☐	Muscle Pain	☐	☐
Headaches	☐	☐	Joint Pain	☐	☐
Fever	☐	☐			
Fatigue	☐	☐			
ENT:			**Breast:**		
Vision Changes	☐	☐	Pain in breast(s)	☐	☐
Spots before eyes	☐	☐	Lump in breast(s)	☐	☐
Sinus Problems	☐	☐	Nipple discharge	☐	☐
Ear problems	☐	☐	Changes to breast skin	☐	☐
Ringing in ears	☐	☐			
Hearing Loss	☐	☐			
Cardiovascular:			**Neurological:**		
Chest pain	☐	☐	Dizziness	☐	☐
Heart racing/skips beats	☐	☐	Numbness in arms/legs	☐	☐
Respiratory:			**Psychiatric:**		
Wheezing	☐	☐	Depression	☐	☐
Shortness of breath	☐	☐	Anxiety	☐	☐
Gastrointestinal:			**Endocrine:**		
Diarrhea/Constipation	☐	☐	Heat/Cold Intolerance	☐	☐
Nausea/Vomiting	☐	☐	Abnormal thirst	☐	☐
Blood in Stool	☐	☐	Hot Flashes	☐	☐
Genitourinary:			**Hematologic/Lymphatic**		
Leaking of urination	☐	☐	Frequent/Easy bruising	☐	☐
Frequency/Urgency	☐	☐	Cuts that do not stop bleeding	☐	☐
Over Active Bladder	☐	☐			
Pain with urination	☐	☐			
Pelvic Pain	☐	☐			
Vaginal itching or Burning	☐	☐			
Abnormal discharge	☐	☐			

Patient Signature ______________________________ Date: ______________________

Please read the following statements below and initial each one

I understand that Total Women's Health and Wellness Center does not bill patients for office visits or Copays. Payment must be made at the time of the visit. Initials ______

I understand that I will be charged a cancellation fee for canceling an appointment less than 24 hours in advance. Initials ______

Failure to keep an appointment will result in a "No Show" fee which must be paid prior to your next visit. Initials ______

I have been given a copy of Total Women's Health and Wellness Center Notice of Privacy Practices to read. (If you have not received Initials this Privacy notice, please see our receptionist for your copy) ______