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_____

Revised 2/17/2016

Gynecology NEW 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:

1. ALLERGIES. Please specify reactions: difficulty with breathing, hives, rash, swelling

Medication	☐ Yes	☐ No	
Latex	☐ Yes	☐ No	
Food	☐ Yes	☐ No	
Other:	☐ Yes	☐ No	

2. CURRENT MEDICATION

Please *include all* prescriptions, over-the-counter medication, vitamins, herbs, health supplements

Name	Dosage	Name	Dosage
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Pharmacies/prescriptions

Pharmacy you use: _____

Do you use mail order? ☐ Yes ☐ No Do you need a refill for any of these meds? ☐ Yes ☐ No

3. HISTORY - YOUR Medical problems

Endometriosis	☐ Yes	☐ No	High cholesterol/triglycerides	☐ Yes	☐ No
Fibroids	☐ Yes	☐ No	Stroke/blood clots in veins, lungs	☐ Yes	☐ No
Infertility	☐ Yes	☐ No	Asthma/lung diseases	☐ Yes	☐ No
Polycystic ovaries/PCOS	☐ Yes	☐ No	Gallbladder/stomach problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Bowel problems:_____	☐ Yes	☐ No
Osteoporosis/Osteopenia	☐ Yes	☐ No	Diabetes Mellitus	☐ Yes	☐ No
Rheumatoid Arthritis/lupus	☐ Yes	☐ No	Thyroid problems:_____	☐ Yes	☐ No
Anemia/blood transfusion	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Cancer :_____	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Heart attack/coronary disease	☐ Yes	☐ No	Bladder infections	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No

Patient's Name _____

Past Gynecological and Obstetrical History

Last normal menstrual period: _____ Age menses began:_____

Monthly periods: ☐ Yes ☐ No If no, how often do you have periods? _____
Total number of days bleeding:_____ Number of heavy days: _____
Average tampon/pad use on a normal day_____Time from start of one to start of next_____

If menopausal, age at last period: _____

Are you currently sexually active? ☐ Yes ☐ No ☐ Never Current partner - for how long: _____

Age of first intercourse: _____ Partners in your lifetime: ☐ greater than 5 ☐ less than 5

Have you had any **abnormal** pap smear? ☐ Yes ☐ No **Treatments:** ☐ Cryo (freezing) ☐ Leep
☐ Colposcopy ☐ None

Current contraception: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Patch ☐ Pill ☐ NuvaRing
☐ Natural Family Planning ☐ Vasectomy ☐ Tubal ☐ Other: _____

Number of Pregnancies:_____

Live births	_____	Vaginal deliveries	_____
Still births	_____	Cesarean sections	_____
Miscarriages	_____	Forceps	_____
Tubal pregnancies	_____	Vacuum	_____
Terminations	_____	Living children	_____

Problems with your pregnancies: _____

_____

Have you ever had:			Date of last one	**Were Results Normal?**		Comments
Pap smear	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Mammogram	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Bone scan	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Cholesterol Check	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Colonoscopy	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____

List all other physicians that you see and the reason

Physician	**Reason**

Patient's Name _____

Surgeries/hospitalization/serious injuries

	Dates		Dates
Appendectomy		Laparoscopies	
Gallbladder		Abdominal surgeries	
Tubal ligation		Hysterectomy	
Breast surgeries		Ovaries removed	☐ Yes ☐ No
C-Section(s)			

Others: _____

_____

Family Problems: List only the closest relatives – children, siblings, parents, grand-parents

		Relatives / important notes
Cancer breast	☐ Yes ☐ No	
Cancer colon	☐ Yes ☐ No	
Cancer cervix	☐ Yes ☐ No	
Cancer body of uterus	☐ Yes ☐ No	
Cancer ovaries	☐ Yes ☐ No	
Cancer skin	☐ Yes ☐ No	
Cancer other:	☐ Yes ☐ No	
Endometriosis	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
High cholesterol	☐ Yes ☐ No	
Heart attack/coronary disease	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Thrombosis (blood clots) legs/lungs	☐ Yes ☐ No	
Diabetes Mellitus	☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No	
Genetic/birth defects	☐ Yes ☐ No	
Other: _____	☐ Yes ☐ No	

Social

Occupation:_____ Number of children: _____

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow ☐ living together

Do you exercise regularly? ☐ Yes ☐ No Routine:_____

Type of exercise:_____

Patient's Name _____

Vaccination/Immunization/Previous disease: List all the shots you have had.

☐ Yes	☐ No	Chicken-pox	☐ Yes	☐ No	Flu-shot	☐ Yes	☐ No	MMR
☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No	Pneumovax23	☐ Yes	☐ No	Tuberculosis test
☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Prevnar 13	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Gardasil/HPV	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No	Tetanus/diphtheria (TDAP) – whooping cough/Acellular Pertussis

☐ Yes ☐ No Are you up-to-date with your tetanus/diphtheria vaccine? (Last shot within last 10 years)
If yes, when was it given? _____

☐ Yes ☐ No Do you want any vaccine today? Which ones?_____

4. TOBACCO/ALCOHOL/SUPPLEMENTS:

Use of tobacco ☐ Never ☐ Past use, quit in : _____ ☐ Current use? 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

Use of street drugs: ☐ Never ☐ Past use ☐ Type/frequency _____
☐ Current ☐ Type/frequency _____

Do you drink caffeine beverages? ☐ Yes ☐ No ☐ coffee ☐ tea ☐ soda ☐other: _____

How many cups or bottles a day? _____

Are you currently dieting? ☐ Yes ☐ No

Which diet? _____

5. MENTAL HEALTH:

	Patient	***Family Members***	Comments
ADD	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Alcohol/drug abuse	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Anxiety/depression	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Bipolar	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Dementia/Alzheimer	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Mental Illness	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Eating Disorders	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____

Patient's Name _____

6. COMMUNICABLE DISEASE HISTORY:

Sexually transmitted diseases:

Have you ever been tested for HIV? ☐ Yes ☐ No Date of the last test? _____

Do you or your partner have or have had a sexually transmitted disease? ☐ Yes ☐ No

☐ Gonorrhea ☐ Chlamydia ☐ Genital warts ☐ Hepatitis B ☐ Hepatitis C

☐ HPV ☐ Herpes ☐ Syphilis ☐ Trichomonas

How often do you use condoms with sex? ☐ Always ☐ Never ☐ Most of the time

☐ Sometimes ☐ Depends on the partner

Other Health Concerns

Would you like testing for sexually transmitted diseases?	☐ Yes ☐ No	_____
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	_____
You 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 current weight?	☐ Yes ☐ No	_____
Are you under a lot stress lately?	☐ Yes ☐ No	Why? _____
Do you have a Living Will/Medical Directive?	☐ Yes ☐ No	_____

Any other issues you want to discuss today?_____

_____

_____

NURSES:

BP: _____ Weight: _____ Height: _____

LMP:_____

Other: _____

the WOMEN'S CLINIC
obstetrics and gynecology

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for **The Women's Clinic** to access my pharmacy benefits data electronically through RxHub. This consent will enable **The Women's Clinic** to:

Determine the pharmacy benefits and drug co-pays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub. This consent is in effect until revoked.

Print Patient's Name	Date of Birth
Patient or Guardian's Signature	Date

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 _____

Gynecology NEW 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:

1. ALLERGIES. Please specify reactions: difficulty with breathing, hives, rash, swelling

Medication	☐ Yes	☐ No	
Latex	☐ Yes	☐ No	
Food	☐ Yes	☐ No	
Other:	☐ Yes	☐ No	

2. CURRENT MEDICATION

Please *include all* prescriptions, over-the-counter medication, vitamins, herbs, health supplements

Name	Dosage	Name	Dosage
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Pharmacies/prescriptions

Pharmacy you use: _____

Do you use mail order? ☐ Yes ☐ No Do you need a refill for any of these meds? ☐ Yes ☐ No

3. HISTORY - YOUR Medical problems

Endometriosis	☐ Yes	☐ No	High cholesterol/triglycerides	☐ Yes	☐ No
Fibroids	☐ Yes	☐ No	Stroke/blood clots in veins, lungs	☐ Yes	☐ No
Infertility	☐ Yes	☐ No	Asthma/lung diseases	☐ Yes	☐ No
Polycystic ovaries/PCOS	☐ Yes	☐ No	Gallbladder/stomach problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Bowel problems:_____	☐ Yes	☐ No
Osteoporosis/Osteopenia	☐ Yes	☐ No	Diabetes Mellitus	☐ Yes	☐ No
Rheumatoid Arthritis/lupus	☐ Yes	☐ No	Thyroid problems:_____	☐ Yes	☐ No
Anemia/blood transfusion	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Cancer :_____	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Heart attack/coronary disease	☐ Yes	☐ No	Bladder infections	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No

Patient's Name _____

Past Gynecological and Obstetrical History

Last normal menstrual period: _____ Age menses began:_____

Monthly periods: ☐ Yes ☐ No If no, how often do you have periods? _____
Total number of days bleeding:_____ Number of heavy days: _____
Average tampon/pad use on a normal day_____Time from start of one to start of next_____

If menopausal, age at last period: _____

Are you currently sexually active? ☐ Yes ☐ No ☐ Never Current partner - for how long: _____

Age of first intercourse: _____ Partners in your lifetime: ☐ greater than 5 ☐ less than 5

Have you had any **abnormal** pap smear? ☐ Yes ☐ No **Treatments:** ☐ Cryo (freezing) ☐ Leep
☐ Colposcopy ☐ None

Current contraception: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Patch ☐ Pill ☐ NuvaRing
☐ Natural Family Planning ☐ Vasectomy ☐ Tubal ☐ Other: _____

Number of Pregnancies:_____

Live births	_____	Vaginal deliveries	_____
Still births	_____	Cesarean sections	_____
Miscarriages	_____	Forceps	_____
Tubal pregnancies	_____	Vacuum	_____
Terminations	_____	Living children	_____

Problems with your pregnancies: _____

_____

Have you ever had:			Date of last one	**Were Results Normal?**		Comments
Pap smear	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Mammogram	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Bone scan	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Cholesterol Check	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____
Colonoscopy	☐ Yes	☐ No	_____	☐ Yes	☐ No	_____

List all other physicians that you see and the reason

Physician	**Reason**

Patient's Name _____

Surgeries/hospitalization/serious injuries

	Dates		Dates
Appendectomy		Laparoscopies	
Gallbladder		Abdominal surgeries	
Tubal ligation		Hysterectomy	
Breast surgeries		Ovaries removed	☐ Yes ☐ No
C-Section(s)			

Others: _____

_____

Family Problems: List only the closest relatives – children, siblings, parents, grand-parents

		Relatives / important notes
Cancer breast	☐ Yes ☐ No	
Cancer colon	☐ Yes ☐ No	
Cancer cervix	☐ Yes ☐ No	
Cancer body of uterus	☐ Yes ☐ No	
Cancer ovaries	☐ Yes ☐ No	
Cancer skin	☐ Yes ☐ No	
Cancer other:	☐ Yes ☐ No	
Endometriosis	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
High cholesterol	☐ Yes ☐ No	
Heart attack/coronary disease	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Thrombosis (blood clots) legs/lungs	☐ Yes ☐ No	
Diabetes Mellitus	☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No	
Genetic/birth defects	☐ Yes ☐ No	
Other: _____	☐ Yes ☐ No	

Social

Occupation:_____ Number of children: _____

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow ☐ living together

Do you exercise regularly? ☐ Yes ☐ No Routine:_____

Type of exercise:_____

Patient's Name _____

Vaccination/Immunization/Previous disease: List all the shots you have had.

☐ Yes	☐ No	Chicken-pox	☐ Yes	☐ No	Flu-shot	☐ Yes	☐ No	MMR
☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No	Pneumovax23	☐ Yes	☐ No	Tuberculosis test
☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Prevnar 13	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Gardasil/HPV	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No	Tetanus/diphtheria (TDAP) – whooping cough/Acellular Pertussis

☐ Yes ☐ No Are you up-to-date with your tetanus/diphtheria vaccine? (Last shot within last 10 years)
If yes, when was it given? _____

☐ Yes ☐ No Do you want any vaccine today? Which ones?_____

4. TOBACCO/ALCOHOL/SUPPLEMENTS:

Use of tobacco ☐ Never ☐ Past use, quit in : _____ ☐ Current use? 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

Use of street drugs: ☐ Never ☐ Past use ☐ Type/frequency _____
☐ Current ☐ Type/frequency _____

Do you drink caffeine beverages? ☐ Yes ☐ No ☐ coffee ☐ tea ☐ soda ☐other: _____

How many cups or bottles a day? _____

Are you currently dieting? ☐ Yes ☐ No

Which diet? _____

5. MENTAL HEALTH:

	Patient	***Family Members***	Comments
ADD	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Alcohol/drug abuse	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Anxiety/depression	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Bipolar	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Dementia/Alzheimer	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Mental Illness	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____
Eating Disorders	☐ Yes ☐ No	☐ *Yes* ☐ *No*	_____

Patient's Name _____

6. COMMUNICABLE DISEASE HISTORY:

Sexually transmitted diseases:

Have you ever been tested for HIV? ☐ Yes ☐ No Date of the last test? _____

Do you or your partner have or have had a sexually transmitted disease? ☐ Yes ☐ No

☐ Gonorrhea ☐ Chlamydia ☐ Genital warts ☐ Hepatitis B ☐ Hepatitis C

☐ HPV ☐ Herpes ☐ Syphilis ☐ Trichomonas

How often do you use condoms with sex? ☐ Always ☐ Never ☐ Most of the time

☐ Sometimes ☐ Depends on the partner

Other Health Concerns

Would you like testing for sexually transmitted diseases?	☐ Yes ☐ No	_____
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	_____
You 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 current weight?	☐ Yes ☐ No	_____
Are you under a lot stress lately?	☐ Yes ☐ No	Why? _____
Do you have a Living Will/Medical Directive?	☐ Yes ☐ No	_____

Any other issues you want to discuss today?_____

_____

_____

NURSES:

BP: _____ Weight: _____ Height: _____

LMP:_____

Other: _____