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 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:_____

Patient's Name _____

- **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?_____

- **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	☐ Yes ☐ No	_____
Last mammogram	_____	Normal	☐ Yes ☐ No	_____
Last bone scan	_____	Normal	☐ Yes ☐ No	_____
Last cholesterol	_____	Normal	☐ Yes ☐ No	_____
Last colonoscopy	_____	Normal	☐ Yes ☐ No	_____

Rev 01/18

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 _____