

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

# Gynecology NEW patient History Questionnaire

**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 <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bone scan <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cholesterol Check <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**List all other physicians that you see and the reason**

Physician	Reason
_____	_____
_____	_____
_____	_____

# Gynecology NEW patient History Questionnaire

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

**Surgeries/hospitalization/serious injuries**

	Dates		Dates
Appendectomy	_____	Laparoscopies	_____
Gallbladder	_____	Abdominal surgeries	_____
Tubal ligation	_____	Hysterectomy	_____
Breast surgeries	_____	Ovaries removed	<input type="checkbox"/> Yes <input type="checkbox"/> No
C-Section(s)	_____		
Others:	_____		
	_____		

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

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

# Gynecology NEW patient History Questionnaire

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

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

- |  |              |  |             |  |  |
|--|--------------|--|-------------|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken-pox  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Flu-shot    | <input type="checkbox"/> Yes <input type="checkbox"/> No | MMR  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumovax23 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis test  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pprevnar 13 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Gardasil/HPV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Meningitis  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetanus/diphtheria (TDAP) –<br>whooping cough/Acellular<br>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:

	<u>Patient</u>	<u>Family Members</u>	<u>Comments</u>
ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alcohol/drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety/depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bipolar	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Dementia/Alzheimer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

# Gynecology NEW patient History Questionnaire

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 \_\_\_\_\_

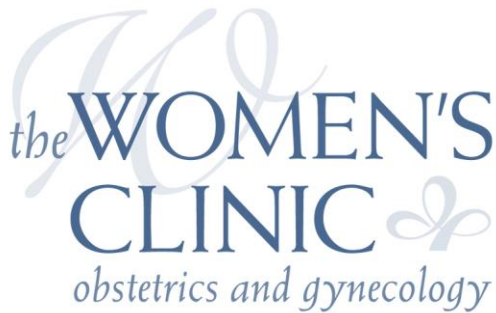
Any other issues you want to discuss today? \_\_\_\_\_

### NURSES:

BP: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

LMP: \_\_\_\_\_

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



*Sumi L. King, M.D., F.A.C.O.G.*  
*Mandy L Winfrey, M.D., F.A.C.O.G.*  
*Ryan Bannon, M.D., F.A.C.O.G.*  
*Gracie E. Moore, M.D., F.A.C.O.G.*  
*Anila Ricks-Cord, M.D., F.A.C.O.G.*  
*Tessa Yates, C.N.M., M.S.N.*  
*Allison Sayre, M.S.N., W.H.N.P.-B.C.*

## 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.

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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 \_\_\_\_\_

August 19, 2015