Consultants in Women's Healthcare, Inc.

Primary Care Physician:

Name:

Date of Birth:

Mailing Address:

Marital Status:

City, State, Zip:

Social Security #:

Home Phone:

Employer Name:

Cell Phone:

Occupation:

Work Phone:

Responsible Party Information (if not the patient)

Parent's Name:

Address:

Social Security #:

Date of Birth:

Emergency Contact Information

Name:

Address:

Phone:

Relationship:

Insurance Information

Primary Insurance:

Policyholder:

Relationship to Patient:

Date of Birth:

Employer:

Secondary Insurance:

Policyholder:

Relationship to Patient:

Date of Birth:

Employer:

How did you hear about us? (Please circle one)

Physician   Family/Friend   Insurance   Google/Internet   Website   Other ___________

Contact Information

Email: ____________________________________

May leave a message: ( ) Home   ( ) Cell

May we leave a message with a family member ( ) No ( ) Yes with: ___________________________________

Your Race: ( ) American Indian ( ) Asian ( ) African American ( ) White ( ) Hispanic ( ) Pacific Islander ( ) Other Race ( ) Refuse to Report

Your Ethnicity: ( ) Latino/Hispanic ( ) Non-Hispanic ( ) Other ( ) Refuse to Report

Pharmacy Name: __________________ Address: ___________________________ Phone: ________________

PLEASE READ THIS. IT IS IMPORTANT. I certify that the information above is true to the best of my knowledge. I accept responsibility for the medical charges incurred and agree to pay all bills at the time of service unless other arrangements are made. In the event my account has to go to a collection agency, I will be responsible for all collection fees incurred by Consultants in Women's Healthcare, Inc. I authorize the release of all medical information, including and without limitation copies of all records and test results produced to designated referral and follow-up physicians and such other healthcare practitioners or organizations who/which will be providing subsequent monitoring, care or treatment in connection with care provided. I also authorize the release of medical information from this medical record in order to comply with applicable laws, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I authorize this office to render medical treatment and to release information to process insurance claims. I also authorize my insurance claim benefits to be paid to the physician or office; I further agree that a photocopy of scanned copy of this document is to be considered as valid as an original. Also, I hereby allow the clinical staff of Consultants in Women's Healthcare to view my medication history from external sources.

Patient Signature (17 and under requires Parent/Guardian signature)   Date   Relationship to Patient

Health History Form

Name: ______________________________ DOB: ______________

Reason for visit today:______________________________

First day of last menstrual period or menopause:______________________

Current birth control method:______________________________

Approximate date of Last pap smear:____________Results:___________

Approximate date of Last Mammogram:__________Results:___________

Approximate date of Last Bone Density:__________Results:___________

Approximate date of Last Colonoscopy:___________Results:__________

Past Medical & Social History

List any personal past illnesses and / or surgeries and when they occurred.

Illness or Surgery:

____

____

Have you ever smoked? Yes No

Do you currently smoke? Yes No

How much do you smoke? ____________

Do you drink alcohol? Yes No

How often do you drink?_____________

Are you on any medications? Yes No

If Yes, please list:______________________________________

Do you have any drug allergies? Yes No

If Yes, please explain:

____

Family History – List all serious illnesses in your immediate family:__________________

____

____

Name: ____ DOB: ____________________

OB History:

Total # of Pregnancies:_____ # of Abortions:______ # of miscarriages:_________

Past Pregnancies:

Date Mo/Day/Yr	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia Yes / No	Place of Delivery	Preterm Labor Yes/No	Com-ments

Review of Systems:

Do you have any problems relating to the following areas?

Periods

Are your periods regular?
How often?

Every _______days/ weeks
Flow lasts_________days
Do you have cramps? Y N
If so, Mild Mod Severe

GYN History

Any prior abnormal pap? Y N
If so, any treatment?_______

Any history of sexually transmitted diseases? Y N
List:____________________

Pelvic

Painful urination Y N
Frequent urination Y N
Urinary Leakage Y N
Pelvic pain Y N
Abdominal pain Y N

Intercourse:

Pain? Y N Bleed? Y N

Constitutional Symptoms
Fever Y N Chills Y N
Headache Y N

Respiratory Wheezing Y N
Shortness of breath Y N

Breast Pain Y N Lump Y N
Nipple Discharge Y N

Do you practice regular self-breast exams? Y N

Menopausal Symptoms
Hot flashes Y N

Night sweats Y N

Psychologic

Depression Y N

Sexual problems Y N

Eyes Vision changes Y N

Pain Y N

Glaucoma Y N

Skin Rash Y N Boils Y N

Health Maintenance

Do you take herbals? Y N
Do you take calcium? Y N
Do you exercise? Y N
What type?__________

Circulation Blood clots Y N
Thrombophlebitis Y N

Gastrointestinal

Diarrhea/ constipation Y N
Nausea / Vomiting Y N
Bloody stools Y N

Jaundice Y N