PATIENT INFORMATION

Patient Name: _____
Last (Maiden) First Middle Initial

Birth Date: _____ S.S. # _____ Nickname (if preferred): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-Mail _____

INSURANCE POLICY HOLDER INFORMATION (IF DIFFERENT FROM PATIENT)

Policy Holder Name: _____ Date of Birth: _____

S.S. # _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

PATIENT EMERGENCY INFORMATION

Spouse's Name: _____ Birth Date: _____

Spouse's Employer: _____ Spouse's Daytime Phone: _____

Emergency Contact (other than spouse) _____

Emergency Contact Phone _____ Relationship to Patient _____

Referring Physician _____ Family Physician _____

Pharmacy _____

Allergies to Medications _____

I AUTHORIZE Woman Care OBGYN to import my medication list.

ASSIGNMENT, RELEASE, and FINANCIAL AGREEMENT: I hereby assign my insurance benefits to be paid directly to Woman Care OBGYN PLC. I also authorize the physician to release any information required to process my claim to my employer or insurance company. I am financially responsible for non-covered services. Failure to pay patient responsibility will result in a 1 ½% finance charge per month overdue.

Signature _____ Date _____
(Patient or parent, if minor)

Woman Care Ob/Gyn Intake History

Name_____ Date: _____ Date of Birth*_____

Age_____ Race*_____ Ethnicity*_____ Primary Language*_____
*Required by Healthcare/Meaningful Use Legislation.

REVIEW OF SYSTEMS Please check all that apply (within the last 6-12 months)

CONSTITUTIONAL ☐ Fever ☐ Chills ☐ Feeling tired ☐ Recent weight loss ☐ Recent weight gain

EYES ☐ Eye pain ☐ Spots before eyes ☐ Double vision ☐ Wearing glasses ☐ Vision changes

EAR/NOSE/THROAT ☐ Earaches ☐ Nose bleeds ☐ Sore throat ☐ Loss of hearing ☐ Sinus problems ☐ Dental problems

CARDIOVASCULAR ☐ Chest pain ☐ Difficulty breathing on exertion ☐ Palpitations ☐ Leg swelling (Edema)

RESPIRATORY ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Shortness of breath on exertion ☐ Coughing up blood

GASTROINTESTINAL ☐ Abdominal pain ☐ Constipation ☐ Heartburn ☐ Vomiting ☐ Diarrhea ☐ Nausea ☐ Blood in stool

URO/GYN ☐ Frequency of urination ☐ Urgency of urination ☐ Blood in urine ☐ Incomplete emptying of bladder ☐ Nocturia ☐ Stress incontinence ☐ Pain with urination ☐ Odor in urine ☐ Urge incontinence ☐ Abnormal bleeding ☐ Vulvar itching ☐ Irregular menses ☐ Midcycle bleeding ☐ Pelvic pain ☐ Pain with menses ☐ Bleeding after intercourse ☐ Vaginal discharge ☐ Pain with intercourse ☐ Decreased libido ☐ Vaginal odor

MUSCULOSKELETAL ☐ Joint pain ☐ Joint swelling ☐ Joint stiffness ☐ Muscle weakness

INTEGUMENTARY (SKIN) ☐ Acne ☐ Itching ☐ Change in a mole ☐ Rash ☐ Breast pain ☐ Breast discharge ☐ Breast lump

NEUROLOGICAL ☐ Dizziness ☐ Numbness ☐ Memory problems ☐ Headaches/Migraines ☐ Difficulty walking ☐ Seizures

PSYCHIATRIC ☐ Suicidal ☐ Anxiety ☐ Change in personality ☐ Sleep disturbances ☐ Depression ☐ Emotional problems

ENDOCRINE ☐ Hair loss ☐ Hot flashes ☐ Dry skin ☐ Heat/Cold intolerance ☐ Abnormal thirst

HEMATOLOGY/IMMUNOLOGY ☐ Easy bleeding ☐ Swollen glands ☐ Easing bruising ☐ Seasonal Allergies

PLEASE LIST ANY ALLERGIES AND REACTION (INCLUDING MEDICATION, FOOD, OR ENVIRONMENTAL)

Medication/Reaction		Food or Environmental/Reaction

PLEASE COMPLETE BOTH SIDES

Surgical History: Please list ALL surgical procedures, or hospitalizations, including year:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medications: Please list ALL names and dosage, and frequency (including Vitamins/Herbal Supplements)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History: Do you now have or have you ever had:

☐ Asthma ☐ Autoimmune disorder ☐ Arthritis ☐ Anemia ☐ Bleeding Disorder ☐ Blood transfusion ☐ Bone/Joint Disease/Fracture
☐ Cancer (type?)_____ ☐ Chicken pox ☐ Chicken pox vaccination ☐ Chlamydia ☐ Chronic Lung Disease
☐ Deep Vein Thrombosis ☐ Depression/Anxiety ☐ Diabetes Type I ☐ Diabetes Type II ☐ Elevated cholesterol ☐ Endometriosis
☐ Uterine Fibroids ☐ GERD/Reflux/Ulcers ☐ GI illness ☐ Gestational Diabetes ☐ Glaucoma ☐ Gonorrhea ☐ Heart disease
☐ Hepatitis ☐ Herpes ☐ Infertility ☐ Irritable Bowel Syndrome ☐ HIV ☐ HPV/genital warts ☐ High Blood Pressure ☐ Hyperthyroidism
☐ Hypothyroidism ☐ Liver Disease ☐ Migraines ☐ Osteopenia ☐ Osteoporosis ☐ Pelvic inflamm. disease ☐ Pneumonia
☐ Rheumatic Fever ☐ Seizures/Epilepsy ☐ Sleep Apnea ☐ Stroke ☐ Syphilis ☐ Thyroid Disease ☐ Trauma ☐ Tuberculosis

Other: _____

_____

Well Woman Update and Reproductive History: (Please provide dates where applicable)

Last bone density exam_____ (month/year) ☐ Abnormal ☐ Normal

Last colonoscopy_____ (month/year) ☐ Abnormal ☐ Normal

Last mammogram_____ (month/year) ☐ Abnormal ☐ Normal

Last Pap smear _____ (month/year) ☐ Abnormal ☐ Normal

*Have you had a Pap smear in the last 7 years? ☐ YES ☐ NO

*Have you ever had: Abnormal Pap smears? ☐ YES ☐ NO or Precancerous cells of the cervix? ☐ YES ☐ NO

If yes, any treatment? (Dates) LEEP_____ Laser _____ Cryo (freezing)_____ Cone Biopsy_____

PLEASE COMPLETE NEXT PAGE

*Did you begin sexual activity before you were 16 years old? ☐ YES ☐ NO

*Have you had more than 5 sexual partners in your lifetime? ☐ YES ☐ NO
*Have you ever tested positive for the HIV virus? ☐ YES ☐ NO
*Did your mother take the drug DES when she was pregnant with you? ☐ Yes ☐ No
(* denotes Medicare "High Risk" Criteria)

Age at first period? _____ If menopausal, age of menopause: _____ ☐ Natural ☐ Surgical Ever use HRT? ☐ YES ☐ NO
How often do you get your menstrual cycle? Every _____ days, lasting _____days. Are your cycles? ☐ Regular ☐ Irregular
Pain/Cramps? ☐ YES ☐ NO Flow: ☐ Heavy ☐ Medium ☐ Light
Date of Last Menstrual Period (start date) _____

Are you sexually active?. ☐ Never ☐ Not currently ☐ Yes ☐ With Men ☐ With Women ☐ With Both

HPV/ Gardasil Vaccine series completed? ☐ YES ☐ NO

Method of contraception: ☐ Not Needed ☐ None ☐ Pill ☐ Vasectomy ☐ Condoms ☐ Patch ☐ Rhythm Method
☐ NuvaRing ☐ Depo Provera ☐ Nexplanon ☐ Mirena IUD ☐ Paragard IUD ☐ Skyla IUD ☐ Tubal Ligation
☐ Essure ☐ Other_____

Obstetrical History:
Number

Pregnancies: _____ Premature: _____ Full Term: _____ Miscarriages: _____ Ectopic: _____ Abortions: _____

Multiple Births: _____ Living Children: _____

Past Pregnancies:
*Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.
Type: vaginal, C/S, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal **Complications:** EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression

Birthdate	Weeks	Labor hrs	Baby's Wt	Sex	Name of Baby	Type of Delivery	Anethesia	Complications	Location

Family History: (Please list which relative, and maternal or paternal side)
Diabetes ☐ YES ☐ NO _____
Stroke ☐ YES ☐ NO _____
Heart Disease ☐ YES ☐ NO _____
High Blood Pressure ☐ YES ☐ NO _____
Alcoholism ☐ YES ☐ NO _____
Breast Cancer ☐ YES ☐ NO _____
Colon Cancer ☐ YES ☐ NO _____
Ovarian Cancer ☐ YES ☐ NO _____
Other types of Cancer ☐ YES ☐ NO _____
Other _____

Social History:

Are you? ☐ Married ☐ Single ☐ Engaged ☐ Significant other ☐ Divorced ☐ Widowed ☐ Same Sex Partner

Your Occupation:_____

School Completed: ☐High School ☐ College ☐ Graduate Degree ☐ Other _____

Tobacco Use: ☐ Never ☐ Current # of Cigarettes per day _____ # Years _____ ☐ Former, Quit at age _____

Any alcohol use? ☐ YES ☐ NO *If yes, the average number of drinks per day _____ per week _____

Do you use street drugs? ☐ YES ☐NO *If yes, the type used and last use _____

Do you wear your seatbelt? ☐ YES ☐ NO

How many times per week do you exercise? (circle) 1X 2X 3X 4X 5X+
How long per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? ☐ YES ☐ NO

Any history of violence or abuse in your current household or in your past? ☐ YES ☐ NO
Has anyone close to you ever threatened to hurt you? ☐ YES ☐ NO
Has anyone ever hit, kicked, choked, or hurt you physically? ☐ YES ☐ NO
Has anyone, including your partner, ever forced you to have sex? ☐ YES ☐ NO
Are you afraid of your partner? ☐ YES ☐ NO

Form Completed by: ☐ Patient ☐ Office staff ☐ Provider

Signature of Patient: _____

Date Reviewed by Provider with Patient: _____

Provider Signature: _____

Annual Review of History:

Date reviewed: _____ Signature of Provider: _____

Date reviewed: _____ Signature of Provider: _____

RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient Name: _____ Physician: _____
Date of Birth: _____ Today's Date: _____
Reason for Today's Visit: _____

This is a screening tool for cancers that run in families. Please consider the following family members:
Mother/Father/Sister/Brother/Children = **1st Degree Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**
Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for a hereditary cancer syndrome? YES _____ NO _____
Have YOU been diagnosed with cancer? What site (organ)? _____ What age? _____

		COLON, UTERINE or OVARIAN CANCER (Lynch Syndrome)	SELF	WHICH FAMILY MEMBER(S)		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) cancer before age 50				
Y	N	Colorectal cancer before age 50				
Y	N	Two or more of the following cancers on the same side of the family: colorectal, uterine, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	N	A family member with a Lynch syndrome mutation				

		HEREDITRY BREAST AND OVARIAN CANCER (HBOC)	SELF	WHICH FAMILY MEMBER(S)		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast cancer at any age				
Y	N	Triple negative breast cancer under the age of 60 (ER, PR and HER2 negative receptor status)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	A family member with a BRCA mutation				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient's signature: _____ **Date:** _____

FOR OFFICE USE ONLY

- ☐ Patient is appropriate for further risk assessment and/or genetic testing
- ☐ Patient offered genetic testing: ACCEPTED OR DECLINED
- ☐ Appointment for Test Results Consult scheduled on: _____

HCP Signature: _____ If declined, Patient Signature: _____