## PATIENT REGISTRATION FORMS

Patient Name: (LAST) _____(FIRST)_____(MI)_____

Street Address: _____

City, State, Zip Code: _____

Email Address: _____

Date of Birth: _____/ _____/ _____

Race: _____ Ethnicity: _____

Phone Number: (HOME) (_____) _____-_____ (CELL) (_____) _____-_____

Pharmacy: (NAME) _____ (PHONE NUMBER) (_____) _____-_____

## EMERGENCY CONTACT

Name: _____ Relation: _____

Phone Number: (_____) _____-_____ [ ] CELL [ ] HOME

## PRIMARY INSURANCE INFORMATION

Please make sure to fill out the highlighted information below

Insurance Company Name: _____

Street Address: _____

City, State, Zip: _____

Insurance Phone Number: (_____) _____-_____

**Responsible Party Name (LAST) _____ (FIRST) _____**

**Relation:** _____ **Date of Birth** _____/ _____/ _____

**Phone Numbers: (CELL) (_____) _____-_____** (HOME) (_____) _____-_____

Subscriber ID Number: _____ Group Number: _____

Specialist Copay: _____ Effective Date: ____/ ____/ _____

# *Follow My Health* Registration

**Personal Account Access**
Patient Ages 12+
(Photo ID Required)

[ ] I am 12-17 years of age and request access to my own medical record information

[ ] I am 12-17 year of age and grant Read Only Access to my medical records to the authorized user listed below

[ ] I am 12-17 years of age and grant Full Access to my medical records to the authorized user listed below

[ ] I am 18 years or older and request access to my own medical record information

[ ] I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below

**Authorized User Access**
Parent / Guardian for patient(s) under age 11
(Legal documents and photo ID required)

[ ] I am 18 years or older and request Read Only Access to a patient medical record

[ ] I am 18 years or older and request Full Access to a patient medical record

[ ] I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient

[ ] I am the parent of a minor aged 11 or younger and possess their birth certificate

**PATIENT INFORMATION**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____/ _____/ _____ Phone Number: (_____)_____-_____

Email address where patient portal messages will be sent: _____

I hereby authorize COMPLETE WOMEN'S HEALTHCARE to use/disclose individually identifiable health information to *Follow My Health* patient portal for my online access to COMPLETE WOMEN'S HEALTHCARE health care information.

Patient Signature: _____ Date: _____

**Authorized User Information**

Authorized User Name: _____

Authorized User DOB: _____/ _____/ _____ Relation to Patient_____

Authorized user email address where portal messages will be sent: _____

Address: _____

Phone Number: (HOME) (_____)_____-_____ (CELL) (_____)_____-_____

Authorized User Signature: _____ Date: _____

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. It is our right to change our privacy practices as the laws permit. We will amend this Notice before any significant changes and will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made. You m ay request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Our office will promptly notify affected individual(s) in the event of a breach of their PHI.

## TYPICAL USES AND DISCLOUSERES OF HEALTH INFORMATION

We will keep your health information confidential using it only for the following purposes

- **Treatment**: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
- **Disclosure**: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you consent that we may do so.
- **Payment**: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may be involved in the process of mailing statements and/or collecting unpaid balances.
- **Emergencies**: We may use or disclose your health information to notify or assist in notification of a family member or anyone responsible for your care in the case of any emergency involving your care. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgement to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.
- **Healthcare Operations**: We will use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under custody of law enforcement.
- **Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to our health and safety or that of others.
- **Public Health Responsibilities**: we will disclose your health information to report problems with product reactions to medication, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.
- **Marketing Health-Related**: WE will not use your health information for marketing purposes unless we have your written authorization to do so.
- **National Security**: The health information of Armed Forces Personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security actives, we may disclose it to authorized federal officials.
- **Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders including but not limited to voicemail messages, postcards, or letters.

# NOTICE OF PRIVACY PRACTICES

## YOUR PRIVACY RIGHTS AS OUR PATIENT

- Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $25.00. If you want copies mailed to you postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for fee and/or explanation of our fee structure.
- Amendment: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- Non-routine disclosures: You have the right to receive a list of non-routine disclosures we have made to your healthcare information. When we make a routine disclosure of your information to a professional for treatment and/or pertinent purposes, we do not keep a record: therefore these are not available. You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request no routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released.
- Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your healthcare information. This request must be submitted in writing. You also have the right to request restrictions for services paid out-of-pocket.

## HELATH INFORMATION EXCHANGE ADDENDUM

Generally, a HIE is an organization that regional providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that a medical error will occur. By participating in a HIE, the provider may share certain health information with other providers that participate in the HIE (each a "participating provider") or participants of other health information exchanges. All participating Providers of HIE agreed to a set of standards relating to their use and disclosures of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. This health information includes, but not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, pap smears, etc.
- Radiology results including x-rays, MRI's, CT Scans, etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary notes
- Urgent Care visit progress notes

# NOTICE OF PRIVACY PRACTICES

## HIE "OPT OUT" OPTION

- If you opt-out, your health information will no longer be accessible through the HIEs in which the provider participates, however, your opt-out does not affect health information that was disclosed through a GHIE prior to the time that you opted-out.
- Regardless of whether you choose to opt-out, your health information will still be provided to the HIEs in which the provider participates, however if you choose to opt-out, the HIEs will not exchange your health information with other provider. Also, you cannot choose to have only certain providers access your health information.
- All participating providers who provide services to you will have the ability to access your information, however, participating providers that do not provide services to you will not have access to your information.
- Information available through a HIE may be provided to others as necessary for Referral, consultation, treatment and/or the provision of other treatment related healthcare services to you. This includes providers, pharmacies, laboratories, etc.
- Your information may be disclosed for payment related activities associated with your treatment by a participating provider and your information may be used for healthcare operations related activities by participating providers.
- You may opt-out at any time by notifying the provider. A form and a list of participating providers may be obtained at the front desk.

## QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our privacy policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a COMPLAINT FORM from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

## CONTACT INFORMATION

Practice Name: COMPLETE WOMEN'S HEALTHCARE

Telephone: (770)622-9810 Fax: (770)622-9811

Email: INFO@WOMENSCAREONLINE.COM

Website: WWW.WOMENSCAREONLINE.COM

Address: 634 Peachtree Parkway
Suite 200
Cumming, GA, 30041

RECEIPT OF NOTICE OF PRIVACY PRACTIVES AND HIE WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of the Complete Women's Healthcare Privacy Practices & HIE Notices

_____ _____

Patient (or responsible party) Signature Date

# PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending provider or their assigned designees

I fully understand this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that COMPLETE WOMEN'S HEALTHCARE will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its content.

_____ _____

Patient (or responsible party) Signature Date

**MEDICARE PATIENTS**: I authorize COMPLETE WOMEN'S HEALTHCARE to release information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to COMPLETE WOMEN'S HEALTHCARE.

_____ _____

Patient (or responsible party) Signature Date

# FINANCIAL AND PAYMENT POLICY FORM

## RETURN CHECK FEES

CHECKS returned for non-sufficient funds will be charged a $30.00 administration fee, in addition to the patient balance.

## HMO, MANAGED CARE AND PPO PLANS

SPECIFIC PLANS may require referrals from primary care physicians. It is YOUR RESPONSIBILITY to provide a current referral form at the time of your visit. You are financially responsible for any services provided without a referral form.

## COPY OF RECORDS / FORMS

COPY OF RECORDS requests require approximately TWO WEEKS to complete. A $25.00 charge is applied for each request. Records less than 20 pages will be faxed; records over 20 pages will be mailed. Emailing records is also an option depending on circumstances. A $25.00 administrative fee is charged for forms and letters completed by our office. This includes verification of pregnancy letters and/or forms for disability, return to work letter, etc. This is a one-time fee payable before forms are completed. This fee will not be submitted to your insurance.

## MISSED APPOINTMENTS

If you are unable to keep your scheduled appointment please notify our office at least 24 hours in advance of your appointment time. Failure to do so will result in a $35.00 no show charge. After 3 no shows on your account you will be dismissed from the practice.

## MISSED, CANCELLED, OR RESCHEDULED PELVIC FLOOR THERAPY APPOINTMENTS.

If you are unable to keep your scheduled appointment please notify our office at least 24 hours in advance of your appointment time. Failure to do so will result in a $50.00 no show charge. After 3 no shows on your account you will be dismissed from the practice.

## CANCELLED SURGERIES

There is a $100 cancellation fee for scheduled surgeries that are cancelled less than 48 hours. We do not know what the hospital cancelation policy is, and therefore you may be required to pay more fees with them.

## DEDUCTIBLE, CO-INSURANCE AND CO-PAYS

All deductibles and co=pays are due at the time of services. We accept cash, checks, Visa and MasterCard. If payment is not received on the date of service, a $20.00 administration fee may apply. All unpaid balances will accrue a monthly 5% late charge if not paid in full after 60 days or not set up on an acceptable payment plan. Complete Women's Healthcare will send all unpaid balances to a collections company after 90 days.

## LABS

We use PATHGROUP for all laboratory services. All labs are billed SEPARATELY through PATHGROUP and you will receive a separate statement for any laboratory services not covered by your insurance. If your insurances requires a specific lab, it is YOUR RESPONSIBILITY to let us know at the time of visit.

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Above is a statement of our financial policy that we would like you to read and sign as evidence of your agreement prior to any treatment.

We must emphasize that as your physician our relationship is with YOU, not your insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date rendered. Not every service is a covered benefit in all contracts. Some insurance companies arbitrarily select your health insurance policy and its requirements for coverage including pre-authorizations of services. We are not responsible for knowing the requirements of your specific plan.

It is your responsibility to contact your insurance carrier to confirm that our office participates in your plan. If you receive services from our office, and we are not on your plan, YOU will be responsible for payments in full for our fee(s).

If you are unable to provide us with current insurance information (a current insurance card or written documentation of coverage from your insurance carrier), or if you do not provide us with the correct insurance information and claims are denied, you will be required to pay for any services you receive. When you have provided us with the corrected insurance information, we will file a claim with your insurance carrier and reimburse you once we have received their payment. Please be aware, if too much time has passed your insurance may not cover your services and you will be required to pay for services.

COMPLETE WOMEN'S HEALTHCARE is not a participating provider of Medicaid, you will be responsible for payment in full if you are insured with them. Patient responsible balances are expected within 30 days. Failure to pay a balance will result in collection actions. If a patient's balance is turned over to a collection agency an additional 30% of the balance will be added to the account.

I have read and understand this financial agreement of COMPLETE WOMEN'S HEALTHCARE. I accept and acknowledge this financial and payment policy by signing below.

_____ _____

Patient (or responsible party) Signature Date

_____

Patient (or responsible party) Printed Name

# Consent for Release of Personal and Health Information

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

This consent form allows personal and health information to be shared via telephone call with the person being authorized. I authorize the use or disclosure of personal and health information by Complete Women's Healthcare as described below. **(Please check which one you agree to, and fill out the blanks if necessary.)**

[ ] Any and all personal and health information Complete Women's Healthcare maintains

[ ] Personal and health information regarding the treatment for the following condition:_____

[ ] Personal and health information covering the period of time from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

[ ] Other (please specify and include dates if needed)

_____

_____

_____

This information may be disclosed to, and used by the following individuals or organizations (healthcare included)

1. Healthcare Provider:_____ Specialty:_____

   Address: _____ Phone Number: (_____) _____ - _____

2. Healthcare Provider:_____ Specialty:_____

   Address: _____ Phone Number: (_____) _____ - _____

3. Name:_____ Relationship:_____

   Address: _____ Phone Number: (_____) _____ - _____

4. Name:_____ Relationship:_____

   Address: _____ Phone Number: (_____) _____ - _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Complete Women's Healthcare. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that I do not have to sign this authorization. I understand that once the information is disclosed the pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

_____ _____

Patient (or responsible party) Signature Date

## WELL WOMAN CONSENT FORM

Name: _____ Date of Birth: _____

You have been scheduled to have a Well-Woman exam today. The annual well woman exam is an essential part of your ongoing health maintenance. Despite changes in recommendations for certain test such as the Pap test, a regular annual exam is strongly recommended. Most health insurance companies will cover most in full, if not all, of the charges associated with this type of visit. Please check with your insurance company to determine how your visit will be covered.

What things are normally considered to be part of the annual well-woman exam?

- A clinical breast and pelvic exam, Pap smear but the frequency of these exams depends on your age, health, and risk factors for certain conditions.
- Reproductive health concerns, birth control options, menstrual, menopause and sexual health
- Breast cancer screening
- Genetic screening for cancer for women with certain risk factors
- Bone density screening
- Screening for sexually transmitted infections (STI's)
- Screening for depression, anxiety and other mental health problems

Any labs that are ordered for you today are billed separately by the lab company. The labs **MAY** or **MAY NOT** be covered by your insurance. Reminder you will received a separate invoice for the lab for any balance or test not covered by your insurance.

Important Note:

The intent of an annual well-woman visit is for routine health maintenance. The assumption is that you do not have any specific medical problems or conditions. If you discuss any problem-oriented issue with your provider (e.g., back pain, breast pain, rashes, sleeping problems, yeast infections, medication adjustments, requesting additional labs other than your preventative routine labs), your insurance may be billed separately and in addition to your well-woman visit since problem-oriented visits usually necessitate a visit. Please review your insurance coverage for more information on what is covered as part of your visit.

Please sign below when you have read and understood this form.

_____

Signature

_____

Date

**THIS BOX FOR OFFICE USE ONLY**

**Wt:** _____ **Ht:**_____ **Bp:**_____ **Ua:**_____

**Orders: [ ] Pap smear [ ] HPV [ ] Mammogram [ ] STI [ ] Labs [ ] Other**_____

# NEW PATIENT MEDICAL HISTORY FORM

Please complete the following information as accurately as possible. Please note that ALL INFORMATION is required and needed for your visit. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

NAME: _____ DATE:_____

DATE OF BIRTH: _____ AGE:_____

PRIMARY CARE PHYSICIAN: _____

PREFERRED LAB: _____

PREFERRED PHARMACY: _____

PHARMACY NUMBER: _____

## REASON FOR VISIT (please check one)

[ ] Annual – Well Woman Check Up

[ ] Problem Visit – please list: _____
(Examples: Menstrual problems, ovarian cysts, UTI, etc.)

## FEMALE GYNECOLOGY HISTORY:

- Date of last menstrual period: _____ / _____ / _____
  MM / DD / YYYY
- NONE due to: [ ] Hysterectomy [ ] Menopausal [ ] Other _____
  (IUD, Birth Control, Etc.)
- Age of first period: _____
- How many days do you bleed: _____
- How many days from one cycle to the next: _____
- Cramping Severity:[ ] NONE [ ] MILD [ ] MEDIUM [ ] STRONG
  [ ] SEVERE
- Flow Severity: [ ] NONE [ ] LIGHT [ ] MEDIUM [ ] HEAVY [ ] CLOTS
- Any problems with your period?[ ] YES [ ] NO

If yes, please explain: _____

## CONTRACEPTION

- Are you currently using a Contraceptive? [ ] YES [ ] NO

  **If yes, what type:**[ ] Pills [ ] Condoms [ ] Abstinence [ ] Partner Vasectomy

  [ ] Withdrawal [ ] Ring [ ] Hysterectomy [ ] Rhythm [ ] Depo-Provera

  [ ] Implant [ ] Menopause [ ] IUD [ ] Foam / Spermicides

  [ ] Tubes Tied / Plugged [ ] Same Gender Partner

- Are you interested in discussing Contraception today? [ ] YES [ ] NO

## HORMONE EVALUATION

- Are you in Menopause? [ ] YES [ ] NO [ ] UNSURE
- Do you or have you ever used hormone therapy?[ ] CURRENTLY [ ] PREVIOUSLY [ ] NEVER
- Are you interested in Bio-Identical Hormone Therapy? [ ] YES [ ] NO [ ] UNSURE
- Do you have any menopausal symptoms? [ ] YES [ ] NO

  **If yes, please list:** _____

  _____

## FEMALE GYNECOLOGY PROBLEMS (PAST AND PRESENT): please check all that apply

[ ] Abnormal Pap Smear [ ] Endometriosis [ ] HPV
Year:_____

[ ] Endometrial (uterine) Ablation [ ] Warts [ ] Laser/LEEP/Freezing of cervix

[ ] Abnormal Mammogram [ ] Genital Herpes [ ] Chlamydia

[ ] Gonorrhea [ ] Other: _____

**PERSONAL MEDICAL HISTORY: (please check all that apply)**

[ ] Asthma [ ] Anemia [ ] Blood Clotting Disorder

[ ] Cancer – type_____ [ ] Mental Disorder [ ] Diabetes

[ ] Heart Disease [ ] Gallbladder Problems [ ] Hypertension / High Blood Pressure

[ ] High Cholesterol [ ] Intestinal Problems [ ] Kidney Problems [ ] Liver Disease

[ ] Migraine [ ] Osteoporosis [ ] Stomach Problems [ ] Stroke [ ] Thyroid Problem

[ ] Infections [ ] Skin Conditions

[ ] Other Problems / Further Details

_____

_____

_____

_____

_____

_____

_____

**ALLERGIES**

| MEDICATION / FOOD NAME | ALLERGIC REACTION TYPE |
|---|---|
| | |
| | |
| | |
| | |
| | |

**MEDICATIONS: Current and regularly taken prescribed medications by healthcare providers (if you have a list please attach)**

| MEDICATION NAME<br>EX: Metformin | STRENGTH<br>500mg | FREQUENCY<br>2x daily | PRESCRIBING DOCTOR<br>Dr. John Doe |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

**SUPPLEMENTS: Supplements, Vitamins, etc.**

| SUPPLEMENT<br>EX: Vitamin D | FREQUENCY<br>1x weekly | REASON FOR USE<br>Vitamin D Deficiency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**FAMILY HISTORY: Place a check next to all that apply**

| MEDICAL HISTORY | ✓ | FAMILY MEMBER (mother, father, maternal or paternal grandparents, aunt, uncle, children, etc.) |
|---|---|---|
| Bleeding Disorder | | |
| Blood Clotting Disorder | | |
| Diabetes (Type 1 or 2) | | |
| Cancer<br>Please list what type w/ family member | | |
| Heart Disease | | |
| Hypertension / High Blood Pressure | | |
| High Cholesterol | | |
| Stroke | | |
| Kidney Problems | | |
| Mental Illness | | |

**PAST SURGICAL HISTORY: Please list ALL surgical procedures with dates performed**

| YEAR | TYPE OF SURGERY | DOCTOR THAT PERFORMED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PREGNANCY HISTORY: Please include abortions or miscarriages**

- Number of times Pregnant: _____
- Number of Miscarriages: _____
- Number of Abortions: _____
- Number of Premature Births: _____
- Number of On-time Births: _____
- Number of Living Children: _____
- Number of Adopted Children: _____

If any, is there anything you would like us to know about the adopted children?

_____

| | YEAR | GA WEEKS | LENGTH OF LABOR | BIRTH WEIGHT | SEX M/F | TYPE OF DELIVERY | ANESTHESIA | PLACE OF DELIVERY | PRE-TERM LABOR | COMMENTS / COMPLICATIONS (abortions or miscarriages included) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |

## SEXUAL ACTIVITY

- Relationship Status: [ ] Married [ ] Single [ ] Engaged [ ] Widowed [ ] Divorced [ ] Dating [ ] Long Term Monogamy
- Sexual Preference: [ ] Men [ ] Women [ ] Both [ ] Unsure
- Are you currently sexually active:[ ] YES [ ] NO
- Have you ever been sexually active:[ ] YES [ ] NO
- Gender of current sexual partner:[ ] Male [ ] Female [ ] Both
- How many partners in the last 12 months? _____
- Current prevention of Sexually Transmitted Infections:[ ] Abstinence [ ] Condoms [ ] Monogamy
- Are you wanting to be tested for STI's today:[ ] YES [ ] NO

  If so, which: [ ] HPV [ ] Chlamydia [ ] Gonorrhea [ ] HIV [ ] Syphilis

  [ ] Hepatitis B

  ***Deductibles or copays may apply to the laboratory when performing the test, Complete Women's Healthcare DOES NOT know your lab benefits

## SOCIAL:

- Your Occupation: _____
- Your Employer: _____
- Relationship Status: [ ] Married [ ] Single [ ] Engaged [ ] Widowed [ ] Divorced [ ] Dating [ ] Long Term Monogamy

  Name of Spouse / Partner: _____

- Do you drink alcohol: [ ] YES [ ] NO [ ] PAST

  If yes, _____ drink(s) per [ ] DAY [ ] WEEK [ ] MONTH

  Any concern about personal alcohol misuse or abuse? [ ] YES [ ] NO

- Do you smoke: [ ] YES [ ] NO [ ] PAST

  If yes type:[ ] Cigarettes [ ] E-Cigarettes

  How many cigarettes a day: _____ How long: _____

  Quit Date: _____

- Do you use recreational drugs: [ ] YES [ ] NO [ ] PAST

  What kind: _____

- Do you drink caffeine: [ ] YES [ ] NO [ ] PAST

  If yes, _____ cups per [ ] DAY [ ] WEEK [ ] MONTH

- Do you exercise regularly? [ ] YES [ ] NO

  How many days per week: _____

  What kind of exercise: _____

- Are you on a special diet / have you made any diet changes: [ ] YES [ ] NO

  [ ] VEGAN [ ] VEGETARIAN [ ] RESTRICTIONS_____

  [ ] OTHER_____

- Have there been any events that have recently caused increased stress that need to be addressed?[ ] YES [ ] NO

  Would you like to explain: _____

## SAFETY

- Is violence at home a concern for you? [ ] YES [ ] NO
- Are you currently or have you ever been a victim of abuse of any kind?
  [ ] YES [ ] NO [ ] PREVIOUSLY
  (Physical, Domestic, Sexual, Psychological, Etc.)

## VACCINE HISTORY: please check all that apply

[ ] HEPATITIS A [ ] MENINGOCOCCAL [ ] HPV (GARDASIL) [ ] SHINGLES [ ] MMR
[ ] FLU [ ] COVID [ ] HEPATITIS B [ ] TDAP [ ] PNEUMOVAX

## HEALTH MAINTENANCE AND MODIFIERS:

| WHEN WAS YOUR LAST | DATE | RESULT(S) | DO YOU NEED AN ORDER/TESTING TODAY |
|---|---|---|---|
| **Pap Smear** | | | |
| **Mammogram** | | | |
| **Colonoscopy** | | | |
| **DEXA / Bone Scan** | | | |
| **Cholesterol / Lipid Screen** | | | |
| **Routine Lab Work** | | | |

## REVIEW OF SYSTEMS: please indicate any recent problems or symptoms

- General:[ ] Excessive fatigue [ ] unexplained weight change (gain or loss)
  [ ] night sweats [ ] hot flashes [ ] heat or cold intolerance

- Breasts:[ ] change in skin [ ] nipple discharge [ ] lumps
  [ ] breast pain

- Respiratory: [ ] unexplained cough [ ] shortness of breath [ ] wheezing

- Gastrointestinal: [ ] vomiting (more than 2 weeks) [ ] chronic diarrhea
  [ ] blood in stool [ ] chronic constipation [ ] persistent nausea
  [ ] bloating (more than 2 weeks)

- Genital / Urinary:[ ] vaginal discharge [ ] vaginal odor [ ] urination urgency
  [ ] leaking of urine [ ] pain with urination
  [ ] blood in urine [ ] problems with sex

- Skin: [ ] new or changing skin lesions

- Neurologic: [ ] intense headaches, new onset

- Cognitive / Emotional: [ ] depression [ ] anxiety [ ] poor sleep
  [ ] inability to concentrate [ ] lack of focus

- Hema-Lymph: [ ] easy bruising or bleeding [ ] enlarged lymph nodes

- Cardiovascular: [ ] chest pain [ ] palpitations

By signing this agreement, I certify that all of the above information is true to the best of my knowledge and beliefs.

_____ _____

Patient (or responsible party) Printed Name Date

_____

Patient (or responsible party) Signature