# *Woman's Clinic, PA*

*Dedicated to women's health for over 50 years. Specializing in routine and high risk pregnancies, gynecologic surgery, laparoscopy, infertility, urinary incontinence, pelvic prolapse, and menopause.*
**Please complete entire form for our physicians.**

Date: ____________ Name: ______________________________ Age: _______ Date of Birth: ____________
Reason for visit (Please Circle) Annual Visit Problem (Description if Problem) ______________________________
Referred by: ______________________________ Primary Care Doctor: ______________________________
How did you hear of the Woman's Clinic, PA? Phone Book Friend Newspaper Ad Doctor Referral Other ____________

## CURRENT MEDICATIONS

| ***Drug Name*** | ***Dosage*** | ***Reason for Medication*** | ***Prescribing Physician*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What is your preferred Pharmacy? ________________ Do you take any over-the-counter medications or herbs? ____________
Are you taking any Hormone Replacements? ________________ Are you taking any Birth Control? ________________
Do you have any allergies? If yes, to what? ______________________________
Are you allergic to Latex? Yes No Are you allergic to Shellfish? Yes No Reaction: ______________________
Do you want more children? Yes No Would you like to talk to the physician about permanent birth control? Yes No

## GYNECOLOGIC HISTORY

Age at first period? __________ Date of your last period? ______________ How many days does it last? ________
How many days from the start of one period to the start of another? ____________ Describe your flow: Light Medium Heavy
Do you bleed between periods? Y N Do you pass clots? Y N Do you have pain with your period? Y N
Do you miss school/work from pain? Y N Are you sexually active? Y N Do you have pain with sex? Y N
Do you have any concerns with your sexual experience? Y N Do you have any STDs? Herpes, Chlamydia, HPV or other? Y N
Have you had an abnormal pap smear? Y N Do you have pelvic pain? Y N Do you have a problem with infertility? Y N
Have you had any procedures on your cervix? If yes, what type? ______________________________

## PREGNANCY HISTORY
**(Please include: Miscarriages, Ectopic Pregnancies and Abortions)**

| # | Date of Birth | Length of Pregnancy | Labor Hours | Birth Weight | Sex of Child | Delivered Vaginally or C-sec? | Epidural, Spinal, IV meds for pain? | Early Labor (Yes/No) | Complications |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
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## MAJOR MEDICAL EVENTS

| Procedure | Date | Procedure | Date | Procedure | Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

## TESTS / IMMUNIZATIONS

| | Date of last: | Result | | Date of last: | Result |
|---|---|---|---|---|---|
| Pap Smear | | | Colonoscopy | | |
| Mammogram | | | Pneumonia / Flu Vaccine | | |
| Bone Density | | | Other Vaccines such as Gardasil and Tetanus | | |

## *YOUR PAST MEDICAL AND FAMILY HISTORY*

| Illness | You | Family Member | Illness | You | Family Member |
|---|---|---|---|---|---|
| Anemia | | | Heart Disease | | |
| Anorexia | | | Heartburn | | |
| Anxiety | | | Hepatitis | | |
| Arthritis | | | High Blood Pressure | | |
| Blood clots in veins | | | Irregular Heart Beat | | |
| Blood Transfusion | | | Kidney Stone | | |
| Breast Cancer | | | Lung Cancer | | |
| Bulimia | | | Lupus | | |
| Cervical Cancer | | | Osteopenia | | |
| Cholesterol Elevation | | | Osteoporosis | | |
| Colon Cancer | | | Ovarian Cancer | | |
| Convulsions | | | Pneumonia | | |
| Crohn's Disease | | | Rheumatic Fever | | |
| Dementia | | | Sickle Cell Disease | | |
| Depression | | | Stomach Cancer | | |
| Diabetes | | | Stomach Ulcer | | |
| Emphysema / COPD | | | Stroke | | |
| Endometriosis | | | Thyroid Disease | | |
| Irritable Bowel Syndrome | | | Tuberculosis | | |
| Fibroids of Uterus | | | Ulcerative Colitis | | |
| Fibrocystic Breast Disease | | | Urinary Leakage | | |
| Headaches | | | Urinary Tract Infection | | |
| Heart Attach | | | Uterine Cancer | | |

## *SOCIAL HISTORY*

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated Occupation: ____________________
Personal Habits: Do you smoke? Y N Packs per day ___________ Are you interested in quitting? ____________
Do you use Alcohol? Y N Drinks per week? __________ Recreational Drug Use? Y N Type? ____________________
Seat Belt Use? Y N Regular Exercise? Y N How often? ________________________________________

Are you currently safe? Y N Has anyone close to you ever threatened to hurt you? Y N Are you afraid of your partner? Y N
Has anyone ever hit, kicked, choked, or hurt you physically? Y N

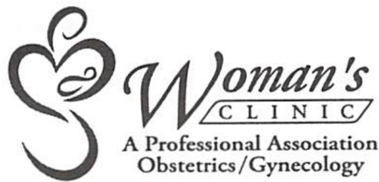
## *REVIEW OF SYMPTOMS (Please mark all that apply)*

| Symptom | Yes | Symptom | Yes | Symptom | Yes | Symptom | Yes |
|---|---|---|---|---|---|---|---|
| Change in Height | | Breast Tenderness | | Blood in Urine | | Muscle Weakness | |
| Fatigue | | Nipple Discharge | | Difficulty with Urinating | | Hair Loss | |
| Loss of Appetite | | Chest Pain | | Frequency of Urination | | Heat/Cold Intolerance | |
| Weight Gain | | Fainting | | Incomplete Emptying of Bladder | | Hot Flashes | |
| Weight Loss | | Irregular Heart Beat | | Painful Urination | | Night Sweats | |
| Blurry Vision | | Lower Extremity Swelling | | Urgency to Urinate | | Anxiety | |
| Dental Problems | | Cough | | Urine Loss with Coughing or Sneezing | | Depression or Frequent Crying | |
| Double Vision | | Shortness of Breath | | Moles (New Growth or Changes) | | Difficulty Sleeping | |
| Headache | | Wheezing | | Rash | | Bleed Easily | |
| Lightheadedness | | Blood in Stool | | Memory Difficulties | | Blood Transfusions | |
| Sore Throat | | Constipation | | Numbness | | Easy Bruising | |
| Vertigo | | Heart Burn | | Joint Pain | | Enlarged Lymph Glands | |
| Breast Lumps | | Involuntary loss of gas or stool | | Muscle Pain | | | |
| Breast Swelling | | Nausea/Vomiting | | | | | |

Form Completed By: _______ Patient ________ Office Nurse Other: ________________________________________

Signature of Patient: ____________________________________________________

Date Reviewed with Patient: ____________________ Physician Signature: ________________________________________




**NOTICE OF PRIVACY PRACTICES**

We keep a record of the health care services we provide you. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to do so. You may get more information by contacting our Medical Records Department or Privacy Officer.

X SIGNATURE ______________________________ DATE ____________________

**AUTHORIZATION TO SHARE HEALTHCARE INFORMATION** I permit you to share my healthcare information with

Name:____________________ or FAX#____________________ Relationship: ____________

(please check all that apply)

- ☐ my healthcare information with exception to pregnancy testing, prenatal care, contraception and STD testing
- ☐ all information to include pregnancy testing, prenatal care, contraception and STD testing
- ☐ only information relating to ______________________________

*This authorization ends only upon my written request.*

X SIGNATURE ______________________________ DATE ____________________

**FINANCIAL POLICY**

Our office is committed to providing quality and cost-effective healthcare to our patients. It is essential that you understand what services are covered by your insurance plan and obtain all authorizations prior to your appointment. Your doctor may recommend services he/she feels are beneficial but may not be covered by insurance. It is your responsibility to understand the limit and restrictions affecting coverage for these services. ***If your insurance company requires you to use a specific lab, it is your responsibility to notify us of this.*** Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we file all claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all co-pays, deductibles, co-insurance amounts along with the entire amount of any non-covered services. Payment for services is expected at the time of service. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office **prior** to receiving services.

X SIGNATURE ______________________________ DATE ____________________

**(Please be advised that this will serve as acknowledgement that you understand Tenncare is not routinely accepted by the Woman's Clinic, P.A. However, you understand that you may ask about an exception to this policy through the Woman's Clinic insurance department and agree to adhere to the qualification guidelines.)**

X SIGNATURE ______________________________ DATE ____________________

**PREVENTATIVE CARE SERVICES**

Your health plan may not provide benefits for preventative services. It is important you determine if your plan offers benefits for this service and their guidelines for it. We use industry standard codes and guidelines to submit insurance claims based on the encounter and documentation in the medical record. Current laws regarding fraud/abuse with billing procedures prohibit us from changing the procedure and/or diagnosis codes in order to get the claim paid by the insurance company.

X SIGNATURE ______________________________ DATE ____________________

**INSURANCE/BILLING INFORMATION**

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to obtain reimbursement. I agree that I am financially responsible for all service provided and should it be necessary to refer the account to a collection business associate, I will be responsible for all fees including but not limited to collection fees, attorney fees, and court costs involved with my account.

X SIGNATURE ______________________________ DATE ____________________

**NO SHOW POLICY** (eff. 1-1-2014)

I am aware that if I fail to appear for scheduled appointments (and fail to cancel appointments) twice within a 6 month time-frame, my account will be assessed a $25 fee for which I will be responsible for paying prior to scheduling another appointment. The Woman's Clinic hopes that this policy, in addition to the reminder service in place, will help to encourage our patients to cancel or reschedule any appointments they are unable to keep.

X SIGNATURE ______________________________ DATE ____________________

**Permission to View Medication History: ☐ Yes ☐ No**