be. Women's Health & Wellness

PATIENT HISTORY QUESTIONNAIRE

A Patient's Name: ________________________________ Date: ______________________

1. Referring Physician: ____________________________
2. How did you hear about us? ____
3. Preferred Phone Number: __________________________________
4. Text/Voice Mails OK: ☐ Yes ☐ No

B **CURRENT MEDICATIONS (Include dose (amount) per day)**

Medication	Dose	Frequency

Name of pharmacy and location:____

C **PAST MEDICAL HISTORY** Check any that apply:

Please list ALL conditions you have been diagnosed with

- ☐ Arthritis
- ☐ Diabetes: Controlled? Y / N
- ☐ Diet ☐ Pill ☐ Insulin
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Other:________________________
- ☐ Kidney Disease
- ☐ Gallstones
- ☐ Liver Disease (including Hepatitis)
- ☐ Epilepsy
- ☐ Blood Transfusions
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ HIV+
- ☐ Eating Disorder

Any drug allergies? ☐ Yes ☐ No If yes: ____

D **PAST SURGICAL HISTORY (NOT OB/GYN)**

5. List all surgeries and their year:

Surgeries	Year

E **PAST OBSTETRICAL/ GYNECOLOGICAL SURGERIES** Check any that apply:

Surgery	Year
☐ D&C	
☐ Hysteroscopy	
☐ Infertility surgery	
☐ Tubal Ligation	
☐ Laparoscopy	
☐ Hysterectomy (Vaginal)/ (Abdominal)	

Surgery	Year
☐ Myomectomy	
☐ Cyst(s) removed ovarian L / R	
☐ Ovary removed L / R	
☐ Vaginal or bladder repair	
☐ Other (specify) ___________	

F **FAMILY HISTORY** **List who Maternal(M) or Paternal(P) & what disease or cancer**

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other:________________

☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer

List :____

G DO YOU CURRENTLY?

6. Smoke? ☐ No ☐ Yes: ____ Packs/day
7. Alcohol? ☐ No ☐ Yes: wine (glasses/day) ____ Beer(Bottles/day)____ Hard Liquid (oz/day) _____
8. Exercise _____________________ How often:______________

H PAST GYNECOLOGICAL HISTORY Check any that apply:

☐ Venereal Warts ☐ Herpes-genital ☐ Syphilis ☐ Pelvic Inflammatory Disease ☐ Chlamydia ☐ Gonorrhea
☐ Endometriosis ☐ Fibroids ☐ Cysts

I MENSTRUAL HISTORY (<u>Complete even if post-menopausal or no longer having periods</u>)

1. First day of last menstrual period ________________________
2. If your menstrual periods are regular; periods start every: __________ days.
3. If you menstrual periods are irregular; periods start every: ____ to ____ days (e.g. 12 to 60).
4. Duration of bleeding: _____ days
5. Age at first period ________Years Menopause __________ Age

J BIRTH CONTROL /SEXUAL HISTORY

1. What birth control method(s) do you currently use? ____
2. Do you have a sexual partner? ☐ Yes ☐ No ☐ Male ☐ Female

K PAP SMEAR/MAMMOGRAM HISTORY

3. Date of last pap smear: _____/______/________
4. Have you had abnormal pap smears? ☐ Yes ☐ No
5. Have you had treatment for abnormal smears? ☐ Yes ☐ No

If Yes what type(s)	Year
Cryotherapy	
Laser	
Cone Biopsy	
Loop Excision (LEEP)	

6. Date of last mammogram: _____________
7. Facility Name: _________________________________
8. Have you had an abnormal mammogram? ☐ Yes ☐ No
9. Have you had a bone density? ☐ No ☐ Yes When _______ Where _________________________
10. Have you had a colonoscopy? ☐ No ☐ Yes When_______ Where___________________________

L PREGNANCY HISTORY (ALL PREGNANCIES)

<u>OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES</u>

						Child		
Year	Location	Duration of Pregnancy	Hours of Labor	Type of Delivery	Complications Mother/Infant	Sex	Birth Weight	Present Health

____________________________________ ______________________________

Patient Signature Date

Patient Demographic Sheet

Last Name: ______________________ First Name: ______________________ Middle: ____________

Address: ____________________________________City: ____________ State: _____ Zip: ________

Home #: _____________________Cell #: ______________________ Work #: ____________________

Race: _________________SSN: _________________________ Date of Birth: _____/_____/________

E-Mail: ____Marital Status: (M / S / D / W)

Religion: _____________Employer: ____________________ Occupation: _______________________

Spouse: ____________________ Date of Birth: _________________ Phone #: ____________________

Emergency Contact: ____

Telephone #: _____________________________ Relationship to Contact: ______________________

Primary Insurance:
Insurance Carrier: _______________________________ Insurance #: ___________________________

Claims Address: ____

Member ID: _______________________Group #: ___________________ Effective Date: __________

Policy Holder Last Name: ______________________ Policy Holder First Name: __________________

Date of Birth: ____/_____/_____ SSN: ________________ Relationship to Patient: ______________

Policy Holder Employer: _____________________________ Employer Phone #: __________________

Acknowledgment:
I certify that the above information is true and correct to the best of my knowledge. I understand the importance of current information and know it is my responsibility to keep this office informed of any changes in my insurance or personal information. I realize any claims that are denied or delayed due to this information not being updated will be my responsibility. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

By signing below, I verity the information above is correct and true.

____ ______________________

(Patient or Legal Representative's Signature) **(Date)**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of *Be. Women's Health and Wellness* Notice of Privacy Practices with the effective date of ___/___/20____.

I give *Be. Women's Health and Wellness* permission to disclose my protected health information to the following individuals:

Name: ____________________________________ Relationship: ____________________________________

Name: ____________________________________ Relationship: ____________________________________

Name: ____________________________________ Relationship: ____________________________________

Name: ____________________________________ Relationship: ____________________________________

I give *Be. Women's Health and Wellness* permission to contact me at the following telephone number or send a message to the most current e-mail address on file:

Telephone Numbers(s): ____

E-mail Address: ____

May we leave a message on the above phone numbers?

YES NO

____
Printed Patient Name

______________________________________ ____________________________
Signature of Patient/Patient Representative Date
(Expires after 12 months)