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 **HEALTH CONCERNS**

1. _____
2. _____
3. _____

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

☐ Diabetes ☐ Heart Disease ☐ Arthritis ☐ Other:_____
☐ High Blood Pressure ☐ Cancer ☐ Asthma
☐ Tuberculosis ☐ Stroke or TIA

List :_____

G DO YOU CURRENTLY?

1. Smoke? ☐ No ☐ Yes: ____ Packs/day ☐ Chew ☐ Pipe Year Quit Smoking _____
2. Alcohol? ☐ No ☐ Yes: wine (glasses/day) ____ Beer(Bottles/day)____ Hard Liquid (oz/day) _____
3. Do you currently use recreational or street drugs? ☐ No ☐ Yes

Have you ever given yourself street drugs with a needle? ☐ No ☐ Yes

H DIAGNOSTIC PROCEDURES

	Normal?
1. PSA: _____/_____/_____	Y ☐ N ☐
2. Prostate Exam: _____/_____/_____	Y ☐ N ☐
3. Colonoscopy: _____/_____/_____	Y ☐ N ☐
4. Bone Density: _____/_____/_____	Y ☐ N ☐
5. Cardiac Scan: _____/_____/_____	Y ☐ N ☐
6. Other: _____/_____/_____	Y ☐ N ☐
7. Last General Physical: _____/_____/_____	Y ☐ N ☐

I HEALTH

EXERCISE: (check box that applies)

☐ Sedentary (No Exercise) ☐ Mild Exercise (i.e., climb stars, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min)
☐ Regular Vigorous Exercise (i.e. work out or recreation 4x/week for 30 min)
Do you work out at a Gym? ☐ Y ☐ N
Do you participate in other sports? ☐ Y ☐ N List here: _____

J SEXUAL HISTORY

1. Do you have a sexual partner? ☐ Yes ☐ No ☐ Male ☐ Female
2. Are there concerns about your sexual activity that you would like to discuss? ☐ Yes ☐ No
3. Have you had a vasectomy? ☐ Yes ☐ No

K BODY COMPOSITION

4. Do you consider yourself: ☐ overweight ☐ just right
5. Have you had unintentional weight loss or gain of 10 pounds or more in the last three months?
   ☐ Yes ☐ No
6. Are you dieting? ☐ Yes ☐ No
7. If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
   # of meals you eat in an average day: _____
8. Salt Intake: ☐ High ☐ Medium ☐ Low
9. Fat Intake: ☐ High ☐ Medium ☐ Low

_____ _____

Patient Signature Date

be. Women's Health & Wellness

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)