WOMEN'S HEALTH RESOURCE - PATIENT INFORMATION SHEET Today's Date: mm/dd/yyyy / /

Patient's Name: Last First Middle Initial

SS#: | | Date of Birth: / / Age:

Address: City State Zip Code

Home Telephone: ( ) Cellular Telephone: ( )

E-Mail:

Marital Status: Married Single Separated Divorced Widow

Preferred Language: English Spanish Other Ethnic Background: Religion:
Spouse's Ethnic Background: Spouse's Religion:

Business Address: City State Zip Code
Work Telephone: ( )

Spouse / Responsible Party:(if minor) SS#: | |
Spouse Business Address: City State Zip Code
Work Telephone: ( ) Other Telephone: ( )

Person to contact in an Emergency: Telephone: ( )

Insurance Information
Do you have Medical Insurance? Yes No
If Yes, name of Primary Insurance Carrier:
Subscriber Name:
ID/ Contract #: Group#:

Name of Secondary Insurance Carrier: (if any)
Subscriber Name:
Contract#: Group#:

Patient's Relation to Insured:
Who referred you to our office?:
Primary Care Doctor: Primary's Telephone: ( )

Assignment and Release
The patient is responsible for all fees, and all professional services are charged to the patient, unless other arrangements have been made in advance. It is also customary to pay for services when rendered. Please do not ask us to bill for Co-Pays.

Insurance Authorization and Assignment
I hereby authorize Womens Health Resource to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance.

Date: / / Signature____

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Women's Health Resource

THE WOMEN'S HEALTH RESOURCE – GYN MEDICAL HISTORY

The Medical History is of utmost importance in the diagnosis and treatment of a patient's condition. Please read the following questions carefully and provide accurate and complete information.

Patient's Name: Last First MI Date: mm/dd/yyyy / /

Reason for today's visit:

Do you think you are pregnant? Yes No Pregnancy test done? Yes No When?: / /

Result?: What date did your last menstrual cycle begin: / /

At what age did you first menstruate?: How often do your periods usually come?:

Your periods come at: Regular Intervals or Irregular Intervals Describe:

For how many days do you bleed?: Is it heavy?: Yes No Clots?: Yes No Painful?: Yes No

Number of times you have been pregnant in the past: Number of living Children: Ages:

List the # of & dates of, each of the following: Example: Abortions: 2 / 03-04, 11-06 (2 Abortions/March 2004 & Nov 2006)

Abortions: / Miscarriages: / Tubal Pregnancies: / Cesareans: /

Are you a virgin? Yes No Have you had sexual intercourse in the last 2 months? Yes No

Do you have a vaginal discharge?: Yes No Color: Odor?: Yes No Itch?: Yes No

Burning/Irritation?: Yes No If yes to any listed, please describe:

Are you presently using any method of birth control to prevent pregnancy?:

Methods used to prevent pregnancy:
At Present:
In the Past:

Do you smoke cigarettes?: Yes No How many cigarettes per day?:

Have you ever been an intravenous drug user?: Yes No When?: Which Drug(s)

Have you ever had sexual relations with a past or present intravenous drug user?: Yes No

PLEASE CONTINUE ON NEXT PAGE

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Check any of the following illnesses you have now or had in the past. If none check HERE:

Asthma	Pelvic Infection	Drug Problem	Gall Bladder Disease/Ulcers
Epilepsy	Tubal Infection	Neurologic Problem	Intestinal Disease/Colitis
Diabetes	S.T.D.	Psychiatric Problem	Lupus/Autoimmune Disease
High Blood Pressure	Chlamydia	Anemia	Heart/Mitral Valve Problem
Kidney Disease	Gonorrhea	Blood Disorder	Hepatitis
Migraine Headaches	Herpes	Bleeding Tendency	Thyroid Problem
Phlebitis	Genital Warts	Ovarian Cysts	Tuberculosis
Pulmonary Embolism	Syphilis	Uterine Fibroids	Urinary Tract Infection

Other Illnesses: (Please list & Describe)

Have you had surgery in the past?: Yes No If yes, list the surgeries, & when & where done:

List any medications or drugs to which you are allergic:

List any medications or drugs you are presently taking, and give dosage:

Do you have problems with your breasts or any urinary, gastrointestinal or bowel problems?: Yes No

Describe:

List any serious illnesses in your family:

Do you examine your breasts on a regular basis?: Yes No Describe:

Have you had a mammography?: Yes No Date of last mammography: / / Result:

List any close relatives who have had breast cancer:

List any relative who has had ovarian cancer:

List any relative who has had osteoporosis:

Have you had a bone densitometry (B.D.) test for osteoporosis?: Yes No If yes, when?:
Result of B.D. Test Treatment?
Your height: Your usual weight: Your Blood Type and Rh, if known

Date: mm/dd/yyyy / / Signature:___________________________________

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