Patient label

MR#____________________

Preferred Women's Healthcare, LLC
Today's Confidential Medical Update

Date: _______________

Patient Name: ____ Date of Birth ____________________________
Age: _____ Marital Status M__ S___ D___ W____ **Allergies to Medications** ______________________________
Current Medications (include vitamins and herbal supplements) ____

Reason for today's visit: ð Annual Exam ð Problem
Are there any problems to discuss? ____

First day of last menstrual cycle: _______________ Pr esent menstrual cycle: ___ Regular ___Irregular # of days ___
Number of pregnancies ____ Number of living children ____
Any history of sexually transmitted disease? (Please check) ☐Herpes ☐HPV ☐ Chlamydia ☐ Gonorrhea ☐ Trichomoniasis ☐ Syphilis ☐ HIV/Aids (V08 or 042)
Are you sexually act ive?☐ Yes ☐ No ☐ Never One partner for ___ months/years
☐ Five or more sexual partners in a lifetime? (V69.2) ☐ Began sexual activity before 16 years of age (V69.2)

What method do you use t o prevent pregnancy?

☐IUD	☐ Implanon	☐Tubal Ligation
☐Essure	☐ NuvaRing	☐Depo-Provera
☐Condoms	☐ Diaphragm	☐Ortho Evra patch
☐Not active	☐ Vasectomy	☐Rhythm method
☐None	☐ Birth control pill (name)____________________	

Social History	**No**	**Yes**	**Occ**
Smoking/PPD	☐	☐	☐
Alcohol	☐	☐	☐
Exercise	☐	☐	☐
Breast exams	☐	☐	☐
Domestic Violence	☐	☐	☐

Current Systems Review (Check or circle if you have no w or have had in last three months)

☐ Fatigue	☐ Chronic cough	☐ Changes in stool	☐ Anxiety or depression	☐ Hot flashes, night sweats
☐ Chest pain	☐ Blood in stool	☐ Shortness in breath	☐ Urinary incontinence	☐ Weight loss or gain
☐ Visual changes	☐ Ringing in ears	☐ Headaches, dizziness	☐ Numbness or tingling	☐ Varicose veins, easy bruising
☐ Nausea, vomiting	☐ Abdominal pain	☐ Diarrhea, constipation	☐ Changes in skin or hair	☐ Loss of consciousness, fainting
☐ None of the above				

Any changes to family history? ________________________________
Any surgeries since last visit? ________________________________
Any old or newly diagnosed chronic problems? ____________________
Physician's seen ________________________________

Last Mammogram ________________
Last Bone Density ________________
Last Colonoscopy________________

I understand that the above in formation is necessar y to provide me wi th medical care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. I will notify the doctor of any change in my health or medications.

Patient/Guardian signature _________________________Pharmacy # ____________________ Date__________________

****OFFICE USE ONLY** DO NOT WRITE BELOW THIS LINE **OFFICE USE ONLY****

Age ____ G ____ P ____ Wt. _____ Ht.____ B/P ________ U/A _______ UPT ____ Hgb ___ Hmc ___ W/P ____

Notes: ____

Providerøs signature _________________________Date ____________

Preferred Women's Healthcare, L.L.C

Patient Information Form

Last Name	First	Middle Initial

Street Address	City	State	Zip
Billing Address (if not the same as above)	**City**	**State**	**Zip**

Home Telephone #	Work Telephone #	Alternative Telephone #
( )	( )	( )

Birthdate	Sex	M	F	Social Security #	Driver's License #

E-mail Address	Single	Married	Divorced	Widowed	Separated	Other

Employer	Employer Address

Spouse(or if Minor/Parent Name)	Birthdate	Social Security #

Employer	Employer Telephone #

Any other last names used?

IN CASE OF EMERGENCY, NEAREST RELATIVE/FRIEND NOT RESIDING AT THE SAME RESIDENCE AS YOURS:

Name	Telephone #		
Address	**City**	**State**	**Zip**

INSURANCE INFORMATION

Name of Insurance Company	Policy Holder's Name	Relationship	Birthdate	Social Security #
Member ID Number		**Group Number**		**Employer**
Name of Add'l Insurance Company	**Policy Holder's Name**	**Relationship**	**Birthdate**	**Social Security #**
Member ID Number		**Group Number**		**Employer**

HOW DID YOU HEAR ABOUT US?

Referred By	Ins. Directory	Friend	Yellow Pages	Internet	Hospital	PWH Website	Physician

Referral's Name

AUTHORIZATION FOR RELEASE OF INFORMATION - I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT - For services furnished by Preferred Women's Healthcare, L.L.C., I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary, all costs of collection, including attorney's fee.

Signature____ Date_______________________________

Family History Questionnaire

Name: ___________________ **Date of Birth: ________________**

Instructions: Please circle **Yes** to those that apply to **YOU** and/or **YOUR FAMILY** (On both your mother OR fatherøs side). Circle **No** if there is no family history. Beside each statement, please list the relationship to you of the individual diagnosed (example: self, mother, maternal aunt, sister) and their age at diagnosis.

HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

			Relationship	Age at Diagnosis
Yes	**No**	Breast cancer before age 50	_______________	_______________
Yes	**No**	Ovarian cancer at any age	_______________	_______________
Yes	**No**	Bilateral breast cancer at any age	_______________	_______________
Yes	**No**	Both breast & ovarian cancer (in an Individual or family at any age)	_______________	_______________
Yes	**No**	Male breast cancer at any age	_______________	_______________
Yes	**No**	2 or more breast cancers (on one side of the family or in an individual	_______________	_______________
Yes	**No**	Ashkenazi Jewish with a personal or family History of breast or ovarian cancer at any age	_______________	_______________

HEREDITARY NONPOLYPOSIS COLORECTAL CANCER SYNDROME

			Relationship	Age at Diagnosis
Yes	**No**	Endometrial cancer before age 50	_______________	_______________
Yes	**No**	Colorectal cancer before age 50	_______________	_______________
Yes	**No**	Colorectal cancer after age 50 and an family member with any cancer below*?	_______________	_______________

***Please circle those that apply:** Colorectal, ovarian, endometrial, stomach, biliary tract, small tract, small bowel, pancreas, kidney (ureter/renal pelvis), brain, sebaceous adenoma

If you circled yes to TWO or more statements on the Family History Questionnaire, you may qualify for a blood test to help determine if you have an inherited risk of cancer.

☐ Patient offered genetic testing ☐ Information given to patient for review ☐ Patient not a candidate

☐ **Accepted** ☐ **Declined** ☐ Follow up appointment scheduled Date: _____________

Pt. Signature ____________________________________ Date ___________________ Dr. Initial _______