Personal Women's Health Care, S.C. and Midwest Essure® Center

YOUR MEDICAL HISTORY

8-PGR

Your Legal Name ______________________________ Today's Date____________

Please check box if address and/or phone numbers have changed ☐

Address______________________City____________________State________ Zip_______

Home phone #__________________________Cell phone #__________________________

Work phone #__________________________ Preferred to be called at: home work cell

Date of Birth______________________Race__________________Ethnicity_____________

Preferred Language____________E-mail_____________________________________

Name of Insurance______________________________ Please circle: PPO HMO POS

Policy Holder's Name ____

Policy Holder's Date of Birth ____________________ Relationship to Patient ______________

Due to insurance policies our office *can no longer* perform a Well Woman Exam and a Problem Visit on the same day.

Are you here today for your Annual Well Women/Preventative Medicine Exam and Pap Smear? _________
OR
Are you here today for a problem? _________ If yes, briefly explain the problem you are having:_________
____

Primary Care Physician: ____________________________ **Phone #**____________________

Preferred Pharmacy: ____________________________**Pharmacy Phone #**__________________

Pharmacy Location: ____

Please list ALL medications you are taking, include non prescription drugs/vitamins/herbals

Medication	Dose	Amount	Times p/day	Tablet, Cream, etc	Reason you are taking this medication

Personal Medical History: Please check if you have ever been diagnosed with the following:

___asthma ___thyroid disorder ___heart disease ___diabetes
___stroke ___autoimmune disease ___high blood pressure ___breast problems
___ mental disorder ___kidney/liver disease ___gastrointestinal problems ___anemia
___osteopenia/osteoporosis ___cancer (type)____________________ other_______________________

Have you had the ***Gardasil*** vaccine (HPV vaccine)? ____________ How many doses? __________

Last Colonoscopy (Date) ______________________________
Last Cholesterol (Date) ______________________________

Allergies to Medications

Medication	Reaction

Allergies: (non- medication allergies)

i.e. Bee Stings	Swelling

Surgical History

Date (Month/Year)	Surgery Performed

Hospitalizations

Date (Month/Year)	

Family history (Please check all that apply and list type of mental disorder or cancer)

Member	Alive (A)/ Deceased (D)	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Disorder	Cancer (with type)
Father	___A ___D						
Mother	___A ___D						
Paternal Grandfather	___A ___D						
Paternal Grandmother	___A ___D						
Maternal Grandfather	___A ___D						
Maternal. Grandmother	___A ___D						
Siblings	___A ___D						
Son(s)	___A ___D						
Daughter(s)	___A ___D						

Mental Health Screening; Please answer below

Feeling down, depressed or hopeless: Yes _____ No _____
Little interest or pleasure in doing things Yes _____ No _____

Social History

Alcohol Use: Yes ________ No________

If yes, how often did you have a drink containing alcohol in the past year?

Monthly or less ________ 2 – 4 p/month ________ 2 - 3 p/ week ________ 4 + p/ week ________

How many drinks on a *typical day* 1 - 2 _____ 3 – 4 ____ 5 – 6 _____ 7 - 9 ____ 10 + _____

How often have you had 6 or more drinks on one occasion in the past year

Never ______ less than monthly ______ monthly ______

Recreational Drug Use: No ______ Yes _____ If yes, please list______________________________

Tobacco Use: Are you a: current smoker _____ former smoker ____ never used tobacco _____

If a current Tobacco user, how often do you smoke Everyday ____ Some days, but not every day

How many times a day do you smoke 5 or less ____ 6 – 10____ 11 – 20____ 21 – 30 ____ 31 or more____

Are you interested in: Ready to quit _____ Thinking about quitting _____ Not ready to quit _____

Living Situation:

Single _______ Married ______ Divorced ______ Separated ______ Widowed ______

Live alone ______ Live with parents _______ Live with roommate(s) ____

Live with boyfriend ______ Domestic partnership ______

Gynecological History

Last menstrual period ______________ Age of first menstrual period ______ Hysterectomy ________

Are you in menopause? Yes _______ No ________ Age at onset of menopause ____

Are your periods regular Yes ______ No ______

How often do you get your periods? # of days apart ____________

How many days flow do you usually have: # of days__________

Is the flow generally: Light _______ Moderate ______ Heavy _______

Do you have pain or cramps: Mild ________ Moderate ________ Severe ________

Last pap (date) ______________________________

Last mammogram (date)_______________________

Type of birth control currently using:_____________________________

Do you use condoms All the time _______ Sometimes _______ Never ________

Sexual History:

Currently having sex _____ Not currently _____ Never been sexually active _____

Sexual Preference: Men _______ Women ________ Both _______ N/A ________

Number of current partners ________

Have you ever had any of the following?

Chlamydia _____ Gonorrhea _____ Herpes _____ HIV ____ Genital Warts _____ Syphilis _____

Check if you have had any of the previous Gynecological problems/procedures

	Abnormal pap smear	Positive HPV	LEEP Procedure	Colposcopy	Pelvic infections	Endometrial biopsy	Endometriosis	Infertility	Ovarian Cyst
Check Here									
Date									

Obstetrical History

Total pregnancies: ______________________

Total Living children: ______________________

Still births: ______________________

Miscarriages: ______________________

Abortions: ______________________

Please list all your pregnancies below

Pregnancy	Date of Delivery	Type: (Vaginal or C-section)	Birth Weight	Term or Pre-term	Complications
Pregnancy #1					
Pregnancy #2					
Pregnancy #3					
Pregnancy #4					

Would you like information on a gentle, hormone free permanent birth control procedure performed in the comfort of our office? Yes______ No _______

If you do not plan to have more children, would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? Yes_______ No_______

If you have involuntary urine loss (stress incontinence) are you interested in information about a simple outpatient procedure to correct this problem? Yes_______ No ________

Please ask us if you do not understand any of the above questions.
I have understood and answered the above questions fully.

SIGNATURE: ____ Date: ________________

I hereby assign the benefits due me through insurance to Personal Women's Health Care, S.C. for services rendered. I authorize and instruct my insurance carrier(s) to make payment of authorized benefits directly to Personal Women's Health Care, S.C. I understand that I am responsible for the charges not paid by the insurance and otherwise, or not covered by this assignment. I also understand that I will be responsible for any collection fee, attorney fees and insufficient fund/returned check fee.
I authorize release of all medical records required to process my claims. This may include Mental Health diagnosis and treatment, Drug and Alcohol Abuse diagnosis and treatment, HIV (AIDS) testing and results unless I specifically request to restrict the release this information.

Print Name ____

SIGNATURE: ____ Date ______________________

PERSONAL WOMEN'S HEALTH CARE, S.C

Dear Patient

Thank you for choosing our office for your medical care. We would like you to know that our office provides the service of a nurse being present for your exam at your request. If a nurse's presence would make your visit more comfortable, please let us know and indicate this below. We assure you that regardless of your preference, your exam will be conducted with privacy and confidentiality. We hope this option will add to our "Personal Women's Health Care". Please sign and date on a line to indicate your choice. You may change this at any time in the future.

Please sign next to your preference

I would like a nurse present for my exams. ______________________________

I **do not** wish a nurse present for my exams. ______________________________

I have no preference. ______________________________

Date: ____________________

PERSONAL WOMEN'S HEALTH CARE, S.C.

Receipt of Notice of Privacy Practices Form

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has received a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any Received Notice will be provided to me or made available.

SIGNATURE: ______________________________________ Date: ____________________

If you are not a patient, please specify your relationship to the patient

____.

PERSONAL WOMEN'S HEALTH CARE, S.C.

MEDICAL INFORMATION RELEASE

In order to comply with HIPPA, we need your permission to release your medical information.

Do we have your permission to leave medical information on your answering machine?

At home Yes ______ No ______ At work Yes ______ No ______ On cell Yes ______ No ______

Do we have your permission to discuss your personal medical care/information with other individuals?

Yes ______ No ______

Person's Name ________________________________

Person's Phone # ________________________________

Relationship to you ________________________________

Person's Name ________________________________

Person's Phone # ________________________________

Relationship to you ________________________________

Additional phone number (s) where you can be reached ______________________

____

Your name (please print) ________________________________

YOUR SIGNATURE ________________________________

Date________________________

Please note: This document will be used until we are notified of any changes

<u>Our Financial Policy</u>

Thank you for choosing our office for your care. We are very concerned about the cost of your medical care. The following is our office financial policy.

Fees: Considerable care was taken in determining our professional fees. We want to assure you that our charges accurately reflect the complexity, the skill and expertise required for your care. We feel our fees are comparable with the fees charged by other specialists in this area. Our fee for the annual Well Woman Exam is $180.00-$250.00 depending on your age and whether you are a new or an established patient.

HMO and PPO Members: Your deductible or co-payment is required at the time of service. If your insurance company requires us to have a referral for care, it is your responsibility to see that we have a correct referral form on hand. Your insurance company may hold you responsible for all charges for care rendered without a required referral form. To avoid delay in your care, we recommend you be aware of any required referral forms and obtain them before your visit.

Records: There is a clerical fee to copy your medical records. The handling fee is $23.78 plus $0.89 cents each for pages 1-24, $0.59 cents each for pages 25-50, and $0.30 cents each for pages 51 to end. Copies made from Microfiche or microfilm $1.48. The fee for completing obstetrical and gynecological disability forms is $25.00.

Collections: Delinquent accounts may be placed with a collection agency. You will be responsible for 30% collection and attorney's fees.

Missed Appointments: Due to the demand for Saturday appointments, there will be a $50 charge if you fail to cancel within 48 hours.

Questions: If you have any questions about your account, insurance reimbursements or our financial policy, please feel free to discuss them with us.

I have read, understood and accept my financial responsibilities under this policy.

______________________________ ______________________________

Patient/Responsible Party's Signature Date