Established Patient Questionnaire **Sound Women's Care** **Today's Date: / /**

Name:____ Date of Birth: ______/______/________ Age: ____________
Last First MI.

Reason for visit:

☐ Routine Preventive Yearly Exam

☐ Referral Primary Care Provider: __________________

☐ Problem (describe) _________________________________

MEDICARE ONLY:

☐ Preventative Yearly exam with Pap/Pelvic/Breast exams

☐ Pap/Pelvic/Breast Exams ONLY

Gynecologic Information:

☐ No Periods

1st Day of last period: ______________

Periods are: ☐ Regular ☐ Irregular

# of days of bleeding: ______

Number of days from 1st day of one period to the 1st day of the next period: ________

Contraception: ___________________ ☐ Not sexually active

Do you have:

Yes	No	
☐	☐	Cramping ☐ Mild ☐ Moderate ☐ Severe
☐	☐	Abnormally heavy bleeding
☐	☐	Bleeding between periods
☐	☐	PMS ☐ Anxiety ☐ Depression ☐ Lack of control ☐ Moodiness
☐	☐	Bleeding with or after intercourse
☐	☐	Pain with or after intercourse
☐	☐	Sexual difficulty - Other
☐	☐	Infertility problems
☐	☐	Abnormal discharge
☐	☐	Hot flashes
☐	☐	Night sweats

Health History Update

Since your last visit, have you had any NEW medical problems, new surgeries or hospitalizations? (Include year)

☐ None ☐ No Change

____
____
____
____
____
____
____

Medications

Include any non-prescription drugs, vitamins, supplements, and birth control pills, as well as frequency and dose.

☐ None

____
____
____
____
____

Current Pharmacy: ________________________________

Location: ______________________________________

Allergies

(List the drug and the reaction you had) ☐ None

____
____
____

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Live with partner

Language: ____

Religion:____

Education Completed: ☐ Grade ☐ H.S. ☐ Voc. ☐ College ☐ Advanced Degree Other: ___________________________

Employment Status: ☐ Working Occupation: ____________________ ☐ Unemployed ☐ Retired ☐ Disabled

Family History: (List the family member and the age diagnosed) ☐ No changes

Alcoholism_________________________	Hay Fever __________________________	Obesity____________________________
Asthma____________________________	Heart Disease______________________	Osteoporosis_______________________
Breast Cancer______________________	High Blood Pressure ________________	Ovarian Cancer ____________________
Colon Cancer ______________________	High Cholesterol____________________	Prostate Cancer ____________________
Diabetes___________________________	Mental Illness (list type) ______________	Stroke_____________________________
Glaucoma _________________________	Migraine___________________________	TB ________________________________

Risk Factors ☐ No changes

Tobacco: ☐ Never

Year started:_____________ Year Quit: ______________

☐ Cigarettes: ______ packs/day ☐ Cigars:______ #/week

☐ Chew: ______ cans/day ☐ Pipe

Passive smoke exposure: ☐ Current ☐ Past

Alcohol: ☐ No ☐ Yes

Type______________________________ # Drinks ________ /day

Caffeine: ☐ No ☐ Yes Drinks/day ___________

Exercise Type:_______________________ Times ______/week

Drugs: ☐ No ☐ Yes Type ___________________________

SIGNATURE: ___________________________________

Review of Systems

Name: ________________________________ DOB: ____________ Date: ________________

Problems you had in the past or are currently experiencing: ☐ **None**

Past	Present	
		General
☐	☐	Weight Loss
☐	☐	Weight Gain
☐	☐	Fevers
☐	☐	Fatigue
☐	☐	Sleep problems
		Breast
☐	☐	Pain
☐	☐	Mass
☐	☐	Nipple Discharge
		Kidney/Bladder
☐	☐	Painful urination
☐	☐	Leakage / incontinence
☐	☐	Frequency
☐	☐	Urgency
☐	☐	Blood in urine
		Cardiovascular
☐	☐	Chest pain or tightness
☐	☐	Palpitations or heart racing
☐	☐	Difficulty breathing
☐	☐	Shortness of breath with exertion
☐	☐	Hand / ankle swelling
		Respiratory
☐	☐	Wheezing
☐	☐	Coughing
☐	☐	Shortness of breath
☐	☐	Coughing blood
		Gastrointestinal
☐	☐	Bleeding from the bowels
☐	☐	Indigestion / heartburn
☐	☐	Gas / bloating
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Difficulty controlling bowel movements
☐	☐	Abdominal pain
☐	☐	Nausea / vomiting
		Endocrine
☐	☐	Hot/Cold intolerance
☐	☐	Hair loss
☐	☐	Hot flashes

Past	Present	
		Musculoskeletal
☐	☐	Muscle or Joint Pain
☐	☐	Muscle weakness
☐	☐	Fractures
☐	☐	Loss of Height
		Skin Problems or Cancerous Growths
☐	☐	Skin Ulcers
☐	☐	Moles
☐	☐	Rashes
		Neurological
☐	☐	Headaches
☐	☐	Numbness
☐	☐	Seizures
☐	☐	Trouble walking
		Mental Health
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Forgetfulness
☐	☐	Job problems
☐	☐	Personal problems
		Eyes / Ears
☐	☐	Vision changes
☐	☐	Wear glasses or contacts
☐	☐	Hearing Loss
☐	☐	Sinusitis
		Allergy
☐	☐	Persistent infections
☐	☐	Hives
☐	☐	Seasonal Allergies
		Blood
☐	☐	History of blood clots in legs or lungs
☐	☐	Easily Bruised
☐	☐	Excessive Bleeding

Signature ______________________________

Prenatal History Questionnaire

Gynecological History		Infection History	
Have you ever had?		**Have you ever had?**	
☐ Y ☐ N	Breast disease	☐ Y ☐ N	Chickenpox
☐ Y ☐ N	An abnormal pap smear	☐ Y ☐ N	Chickenpox vaccine
☐ Y ☐ N	Infertility/Artificial Insemination Treatment	☐ Y ☐ N	Genital Herpes
☐ Y ☐ N	DES exposure	☐ Y ☐ N	A partner with a history of Genital Herpes
☐ Y ☐ N	GYN disorder	☐ Y ☐ N	A STD (GC, Chlamydia, Syphilis, HIV)

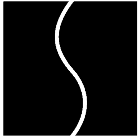
Medical History		Risk Factors	
Have you ever had?		☐ Y ☐ N	Do you currently smoke?
☐ Y ☐ N	Disease in your Head, Eyes, Ears, Nose, or Throat	☐ Y ☐ N	Have you ever smoked in the past?
☐ Y ☐ N	Heart Disease		If yes, what year did you quit? ______________
☐ Y ☐ N	Hypertension	☐ Y ☐ N	Do you live with/work with someone who smokes?
☐ Y ☐ N	Pre-Ecclampsia	☐ Y ☐ N	Do you currently use alcoholic beverages?
☐ Y ☐ N	Lung Problems	☐ Y ☐ N	Prior to this pregnancy did you consume alcoholic beverages?
☐ Y ☐ N	GI/Liver/Hepatitis Disease		
☐ Y ☐ N	Gynecologic or Urinary Disorder		If yes, how often did you drink alcoholic beverages? ______________________________
☐ Y ☐ N	Frequent Urinary Tract Infections		
☐ Y ☐ N	Diabetes		If yes, how many alcoholic beverages did you usually have per occasion? ____________________
☐ Y ☐ N	Gestational Diabetes		
☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N	Do you currently use street drugs?
☐ Y ☐ N	Neurological Disorders		If yes, what? ___________________
☐ Y ☐ N	Seizures	☐ Y ☐ N	Do you have a history of alcohol or substance abuse?
☐ Y ☐ N	Migraine		
☐ Y ☐ N	Bleeding/Clotting Disorder	☐ Y ☐ N	Have you ever sought and/or received treatment for alcohol or drug problems? If yes, when? __________
☐ Y ☐ N	Psychiatric Disorder		
☐ Y ☐ N	Depression	☐ Y ☐ N	Have you used any medications since your last menstrual period? If yes, what medicine? _________
☐ Y ☐ N	Postpartum Depression		
☐ Y ☐ N	Anxiety Disorder	☐ Y ☐ N	Did you use Folic Acid prior to your pregnancy?
☐ Y ☐ N	Musculoskeletal Disorders	☐ Y ☐ N	Have you been exposed to X-rays since you last menstrual period?
☐ Y ☐ N	Skin Disorders		
☐ Y ☐ N	Transfusions	**Infection Risk History**	
☐ Y ☐ N	Prior C-Sections	☐ Y ☐ N	Are you at a high risk for Hepatitis B infection?
☐ Y ☐ N	Other Surgery: ______________________________	☐ Y ☐ N	Are you immunized against Hepatitis B?
☐ Y ☐ N	Sexual Abuse	☐ Y ☐ N	Have you been exposed to TB?
☐ Y ☐ N	Domestic Violence	**Environmental Exposures**	
Has anyone in your family ever had?		☐ Y ☐ N	Have you had a rash, viral or febrile illness since your last menstrual period?
☐ Y ☐ N	Diabetes		
☐ Y ☐ N	Hypertension	☐ Y ☐ N	Do you have any occupational exposure to children? If yes, what is your occupation: _______________
☐ Y ☐ N	Multiple Gestation		
☐ Y ☐ N	Other : ____________________________	☐ Y ☐ N	Do you have a history of Parvovirus (Fifth Disease)?
		☐ Y ☐ N	Have you been exposed to any chemicals?
For office use: *Place patient label here*		☐ Y ☐ N	Have you been exposed to cat litter since your last menstrual period?
		☐ Y ☐ N	Have you ever had other exposure you think we should be aware of? If yes, what kind?

Prenatal History Questionnaire

Patient's Family Genetic History		Father of Baby's Family Genetic History	
Do you have a family history of		Does the father of the baby have a family history of	
☐ Y ☐ N	Thalassemia	☐ Y ☐ N	Thalassemia
☐ Y ☐ N	Neural Tube Defect	☐ Y ☐ N	Neural Tube Defect
☐ Y ☐ N	Down Syndrome	☐ Y ☐ N	Down Syndrome
☐ Y ☐ N	Tay-Sachs	☐ Y ☐ N	Tay-Sachs
☐ Y ☐ N	Sickle Cell Disease/Trait	☐ Y ☐ N	Sickle Cell Disease/Trait
☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Hemophilia
☐ Y ☐ N	Muscular Dystrophy	☐ Y ☐ N	Muscular Dystrophy
☐ Y ☐ N	Cystic Fibrosis	☐ Y ☐ N	Cystic Fibrosis
☐ Y ☐ N	Huntington's Disease	☐ Y ☐ N	Huntington's Disease
☐ Y ☐ N	Mental Retardation	☐ Y ☐ N	Mental Retardation
☐ Y ☐ N	Fragile X	☐ Y ☐ N	Fragile X
☐ Y ☐ N	Other Genetic/Chromosomal defects	☐ Y ☐ N	Other Genetic/Chromosomal defects
☐ Y ☐ N	Birth of child with other birth defects	☐ Y ☐ N	Birth of child with other birth defects
☐ Y ☐ N	Stillbirth	☐ Y ☐ N	Stillbirth
☐ Y ☐ N	Other (spina bifida, heart defect, blood disorder)	☐ Y ☐ N	Other (spina bifida, heart defect, blood disorder)

Other questions	
☐ Y ☐ N	Will you be 35 years or older when the baby is due? Age when due: ________________
☐ Y ☐ N	Are you or the baby's father related to each other? (i.e. cousins)?
☐ Y ☐ N	Have you had three or more pregnancies that ended in miscarriage?
☐ Y ☐ N	Have you delivered a premature baby?
☐ Y ☐ N	Have you or the baby's father had a stillborn baby, a baby who died around the time of delivery, or a baby who was small for gestational age?
☐ Y ☐ N	Where your ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of these ethnic/racial groups: Jewish, Black, Asian, Mediterranean (Greek, Italian)?
☐ Y ☐ N	Have you or the baby's father ever been screened to see if either of you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia, or Cystic Fibrosis?
☐ Y ☐ N	Do you think you are at an increased risk of having a baby with a birth defect or genetic disorder? If yes, which defect or disorder? _____________ Why do you think you are at an increased risk? ___________________
☐ Y ☐ N	At any time during the first two months of your pregnancy, have you had a rash or a fever of 103°F or greater?
☐ Y ☐ N ☐ Unsure	Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?
☐ Y ☐ N ☐ Unsure	Do you think any of your male sexual partners have ever had sex with other men?
☐ Y ☐ N ☐ Unsure	Have you or your sexual partners ever used IV street drugs?
☐ Y ☐ N ☐ Unsure	Have you had sex with two or more partners in the last twelve months?
☐ Y ☐ N ☐ Unsure	Do you think any of your sexual partners may have HIV or AIDS?
☐ Y ☐ N ☐ Unsure	Have you or your sexual partners ever had a blood transfusion?
☐ Y ☐ N	Do you feel safe in your personal relationship?
☐ Y ☐ N	Do you feel safe within your home?
☐ Y ☐ N	Do you feel safe in your own neighborhood?
☐ Y ☐ N	Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced any other kinds of hurting?
If you're under 18, and you answer yes to the following questions, your care provider must report this information to Child Protective Services.	
☐ Y ☐ N	Are you being or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt? If yes, by whom? ☐ Husband ☐ Family Member ☐ Ex-Husband ☐ Stranger ☐ Partner ☐ Other (specify) _______________
☐ Y ☐ N	Are you experiencing or have ever experienced uncomfortable touching or forced sexual contact? If yes, by whom? ☐ Husband ☐ Family Member ☐ Ex-Husband ☐ Stranger ☐ Partner ☐ Other (specify) _______________

Patient Signature: ________________________________ *Date:* _____________________



SOUND WOMEN'S CARE

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Where would you prefer we contact you with **CONFIDENTIAL** information regarding your treatment or test results? Please leave at least one number where we could leave you a message.

Voicemail okay?

Home Yes _______ Number:_____________________ Yes ______ No ______

No _______

OR **Voicemail okay?**

Work Yes ________ Number:_____________________ Yes ______ No ______

No ________

OR **Voicemail okay?**

Cell Yes ________ Number: _____________________ Yes ______ No ______

No ________

I give permission for medical information about me to be shared with the following:

____

____ **(Signature of Patient)**

By my signature below, I acknowledge receipt of the Notice of Privacy Practices and give my permission regarding a confidential voice message as stated above.

I also hereby authorize my insurance benefits to be paid directly to Sound Women's Care, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers for payment of claims. I also authorize the release of information I request to be sent to insurance companies or employers (including disability forms).

____ _____________________

PRINT NAME Date of Birth

____ _____________________________

Patient or legally authorized individual signature Today's Date

____ _____________________________

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

Last Update: 9-22-09

7-12-2010