

New Patient Questionnaire, Page 2

Pregnancy History

Total Pregnancies # _____ Live Births # _____ Miscarriages # _____ Abortions # _____
Ectopic(tubal) pregnancies # _____ C-Sections # _____

Children's Birth Information:

	Birthdate	Wt	Sex	Complications		Birthdate	Wt	Sex	Complications
1					5				
2					6				
3					7				
4					8				

Family History

Natural Mother: Living, Age _____ Health Problems Deceased, Age _____ Cause of Death _____

Natural Father: Living, Age _____ Health Problems Deceased, Age _____ Cause of Death _____

Siblings: _____ Health Problems _____

Children: _____ Health Problems _____

Has anyone had:

Yes No

Heart attack or stroke before age 50

High blood pressure

Diabetes

Yes No

Osteoporosis, frequent fractures

Cancer Who: _____ Part of body: _____

Other: _____

Social History

Marital Status: Single Married Separated Divorced Widowed Living w/ Partner

Education: Grade H.S. Voc. College Advanced Degree

Language: _____ Religion: _____

Employment Status

Working Occupation: _____ Retired At Home/Child Care Disabled Unemployed

Risk Factors

Tobacco: Age started: _____ Year Quit: _____ Never Passive smoke exposure: current past

Cigarettes: _____ pck/day

Alcohol: Type _____ # Drinks: _____/day _____/week _____/month _____/year

Drugs: Which recreational drug do you use? None Cocaine Marijuana Other: _____

Caffeine: Coffee Tea Cola Cups/day _____

Exercise: Type: _____ Times per week _____

Current Immunizations: Tetanus Flu Pneumonia Rubella Hepatitis Polio

Seatbelt use (%) _____

Examine your breasts: Occasionally Regularly

SIGNATURE: _____

Review of Systems

Name: _____ DOB: _____ Date: _____

Problems you had in the past or are currently experiencing:

None

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

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

Signature _____



NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

SOUND
WOMEN'S
CARE

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.

Home Yes _____ Number: _____ **Voicemail okay?**
Yes _____ No _____
No _____

OR

Work Yes _____ Number: _____ **Voicemail okay?**
Yes _____ No _____
No _____

OR

Cell Yes _____ Number: _____ **Voicemail okay?**
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.