Name:__________ Date:__________ Marital Status:__________

Date of Birth:____/____/____ Race:__________ Preferred Language:__________

Social Security No:____-____-____

Address:__________ City:__________ State: _____ Zip:__________

Home Phone:__________ Cell Phone:__________ Email:__________

Patient's Employer:__________ Phone : __________

Spouse's Employer:__________ Phone :__________

Referring Physician:__________ Phone:__________

Primary Care Physician:__________ Phone:__________

Emergency Contact:__________ Phone__________

Local Pharmacy__________ Address (Cross Streets):__________ Phone:__________

Is it OK to leave medical information on your answering machine or voicemail? ◯ ***YES*** ◯***NO***

You authorize us to share your Protected Health Information with the following person(s) (until you notify us otherwise):

Name:__________ Relationship:__________ DOB:____/____/____

Name:__________ Relationship:__________ DOB:____/____/____

Primary Insurance:__________

ID Number:_______ Group Number_______

Policy Holder's Name:__________

DOB:___/___/___ Social Security No:___-___-___

Secondary Insurance:__________

ID Number:_______ Group Number_______

Policy Holder's Name:__________

DOB:___/___/___ Social Security No:___-___-___

Please carefully read and sign both statements below:

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I understand that regardless of the insurance coverage that I may have, I am responsible for paying all charges. In event of non-payment of charges for the services rendered, I agree to pay all costs of collection, including reasonable attorney's fees. I have read this agreement and do understand its provisions.

Patient or Responsible Party__________ Date__________

I hereby authorize Women's Health Now to send me newsletters, bulletins, and other documents via email. I understand the Women's Health Now will not share my email address with any other person or agencies with my express written consent. This authorization will remain in effect until I revoke thi authorization.

Patient or Responsible Party__________ Date__________

Patient Medical Information
Check in Sheet

Name__________________________ DOB_______________ Date ______________

Height: Feet_____ Inches_______

1. What is your reason for today's visit?

   ____

   ____

2. Are you allergic to any medications? ____
   If yes, please list and reaction:

   ____

   ____

   ____

3. What medications are you taking? Please list with dosages:

   ____

   ____

   ____

   ____

   ____

Contraception	***Bleeding***	***Paps***	***Breast Cancer***
What is your current form of birth control? ____________ Condoms? Yes No	When was your last period? ____________ Number of days between periods?__________	Date of your last pap ______________ Normal Abnormal	Date of your last Mammogram ______________ Normal Abnormal If abnormal, what?________ ________________
Sterilization: Male Female	Number of days of flow?__________	Have you ever had an abnormal pap? Yes No	Do you perform self-breast exams? Yes No
IUD: Yes No If yes, what type? __________	Heavy? Yes No	Treatment? Yes No	How often do you perform self-breast exams? Monthly Occasionally Never
Birth Control Pills: Yes No If yes, what type? ________	Are your periods regular? Yes No	If yes, type? Date: Leep____________ Colposcopy________	Other?____________
Injection? Yes No If yes, what type? ____________	Do you have pain with your periods? Yes No	Laser____________ Cryotherapy________	***Smoke*** Do you smoke? Yes No If yes, how often? ______________
Other?__________	Do you have bleeding in between your periods? Yes No	Other?__________________	

4. Please mark any condition that you have or have had in the past:

Have you ever had:	Yes/Date Diagnosed		Yes/Date Diagnosed		Yes/Date Diagnosed
Epilepsy		Kidney Disease		Gonorrhea	
Heart Disease		Hepatitis		Chlamydia	
Heart Attack		Thyroid Disorder		Syphilis	
Heart Murmur		Bowel Disease		Genital Herpes	
Stroke		Arthritis or Lupus		HIV/AIDS	
Blood Disease		Depression		**Recurrent Urinary Tract Infections**	
Blood Clots		High Blood Pressure		**Bacterial Vaginosis (BV)**	
Anemia		Scarlet Fever		**Scarlet Fever**	
Diabetes		Chicken Pox		**Syphilis**	
Asthma		Rheumatic Fever		Trichomonas	
Migraine Headaches		Type of Cancer		Pelvic Inflammatory Disease (PID)	
Other		Breast Cancer		Human Papillomavirus (HPV)	

Pregnancy History

Total Pregnancies ______ Deliveries _______Miscarriages _________ Abortions ___________

Year of Delivery	Vaginal, C-Section or Miscarriage, Abortions

Past Surgical History

Date of Surgery	Type of Surgery

Family History

1. Were you adopted? ☐Yes ☐No

No Family History ☐

Has any blood relative ever had any of the following?

Relationship to You	Maternal (Mom's Family)	Paternal (Dad's Family)	Age at Diagnosis	Disease Yes/No	Deceased Yes/NO
				Breast Cancer	
				Ovarian Cancer	
				Colon Cancer	
				Osteoporosis	
				Stroke	
				Heart Attack	
				Diabetes	
				Blood Clots	
				High Blood Pressure	
				Other	