## PATIENT INFORMATION

TODAY'S DATE _____ PREFERRED PHARMACY_____LOCATION_____

PATIENT'S NAME _____ DATE OF BIRTH _____ SS# _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ NATIVE HAWAIIAN
☐ AMERICAN INDIAN ☐ HISPANIC ☐ OTHER _____

ETHNICITY_____ PREFERRED LANGUAGE_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE_____

PRIMARY PHONE _____ EMAIL_____

PREFERRED CONTACT FOR APPOINTMENT REMINDERS **PLEASE CIRCLE ONE** CELL HOME TEXT EMAIL PATIENT PORTAL

SPOUSE'S NAME _____ DATE OF BIRTH _____ SS# _____
(OR RESPONSIBLE PARTY)

FAMILY DOCTOR _____ PREVIOUS OB/GYN SEEN _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DO YOU HAVE A LIVING WILL? _____ DO YOU HAVE A DURABLE POWER OF ATTORNEY? _____

## EMPLOYER INFORMATION

**PLEASE CIRCLE ONE**

PATIENT'S EMPLOYER _____ FULL TIME PART TIME UNEMPLOYED RETIRED

SPOUSE'S EMPLOYER _____ FULL TIME PART TIME UNEMPLOYED RETIRED
(OR RESPONSIBLE PARTY)

## EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____

I hereby authorize The Center for Women, Inc. to apply for benefits on my behalf for services rendered by them or by their order. I request payment from my insurance company to be made directly to The Center for Women, Inc. I certify that the information reported with regard to my insurance coverage is correct. If my insurance does not cover the cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for collection costs including but not limited to collection agency fees, court costs, and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

**I have read, fully understand and agree to the above**

SIGNATURE _____ DATE _____

**THE CENTER FOR WOMEN, INC.**
**4139 BOARDMAN-CANFIELD ROAD • CANFIELD, OH 44406**
**PHONE (330) 702-1281 • FAX (330) 702-1287**

# PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____ Age: _____ Date: _____

REASON FOR VISIT: _____

GENDER IDENTITY: ☐ FEMALE ☐ OTHER _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LIFE PARTNER

SEXUAL ORIENTATION: ☐ STRAIGHT/HETEROSEXUAL ☐ LESBIAN/GAY ☐ BISEXUAL ☐ OTHER ☐ DECLINE

First day of last menstrual period: _____ ☐ Not applicable due to: ☐ Menopause ☐ Mirena/Liletta IUD ☐ Hysterectomy ☐ DepoProvera ☐ Ablation ☐ Other

Flow: ☐ Light ☐ Medium ☐ Heavy Clots: ☐ Yes ☐ No Severe Cramps: ☐ Yes ☐ No # of days you bleed: _____

# of days between periods: _____ (i.e. 28,30)

Are you in a sexual relationship? _____

Number of **NEW** sexual partners since last visit: _____ Gender of current sexual partner _____

Do you want STD testing? ☐ Yes ☐ No

Type of contraception currently used: ☐ Pills ☐ NuvaRing ☐ DepoProvera ☐ Condoms ☐ Tubal Ligation ☐ Vasectomy ☐ IUD ☐ Essure ☐ Nexplanon ☐ Other _____

Colonoscopy: Date: _____ Result: _____ Cologuard: Date: _____ Result: _____

Date of last Mammogram: _____ Date of last Bone Density: _____

| | | | | |
|---|---|---|---|---|
| Alcohol Use: | ☐ Never | ☐ Current | ☐ Former | Amount _____ |
| Recreational Drug Use: | ☐ Never | ☐ Current | ☐ Former | Amount _____ |
| Tobacco Use: | ☐ Never | ☐ Current | ☐ Former | Amount _____ |
| Vape Use: | ☐ Never | ☐ Current | ☐ Former | Amount _____ |

Domestic Violence: Emotional: ☐ Current ☐ Past Physical: ☐ Current ☐ Past Sexual: ☐ Current ☐ Past

**REVIEW OF SYSTEMS** Please check if you are **CURRENTLY** experiencing any of these symptoms.

| **CONSTITUTIONAL** | **GASTROINTESTINAL** | **INTEGUMENTARY** |
|---|---|---|
| ☐ Unexplained Weight Loss | ☐ Heartburn | ☐ Rash |
| ☐ Unexplained Weight Gain | ☐ Nausea | ☐ Skin Lesions |
| ☐ Fever | ☐ Vomiting | **NEUROLOGIC** |
| ☐ Excessive Thirst | ☐ Abdominal Pain | ☐ Seizures |
| ☐ Excessive Urination | ☐ Bloating | ☐ Dizziness |
| **HEENT** | ☐ Diarrhea | ☐ Syncope (Fainting / Passing Out) |
| ☐ Headaches | ☐ Constipation | **ENDOCRINE** |
| ☐ Problems with Teeth/Gums | ☐ Bloody Stool | ☐ Cold Intolerance |
| **BREAST** | **GENITOURINARY** | ☐ Heat Intolerance |
| ☐ Breast Lumps | ☐ Pain with Intercourse | ☐ Excessive Hair Growth |
| ☐ Breast Pain | ☐ Spotting With or After Intercourse | |
| ☐ Breast Discharge | ☐ Abnormal Vaginal Discharge | |
| ☐ Changes in Skin | ☐ Vaginal Dryness | |
| **CARDIOVASCULAR** | ☐ Urinary Frequency | |
| ☐ Chest Pain | ☐ Urinary Urgency | |
| ☐ Heart Palpitations | ☐ Urinary Retention | |
| **RESPIRATORY** | ☐ Painful Urination | |
| ☐ Wheezing | ☐ Blood in Urine | |
| ☐ Shortness of Breath | ☐ Incontinence | |
| ☐ Cough | | |

Patient's Signature: _____ Doctor's Signature: _____

# PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their protected heath information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received The Center for Women's Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is also available at all times in The Center for Women's waiting room and I may request an additional copy of it at any time by contacting the Office Manager at 330-702-1281.

## I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Work Telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work address
- ☐ Other _____

## YOU MAY DISCUSS MY HEALTH INFORMATION WITH:

| NAME | RELATIONSHIP | PHONE |
|---|---|---|
| | | |
| | | |
| | | |

_____ _____
Patient Signature Date

_____ _____
Printed Name Date of Birth