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: _____ DATE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

REASON FOR VISIT: _____ DOB: _____ Age: _____

Last menstrual period: _____ ☐ Not applicable due to: ☐ Menopause ☐ Mirena/Liletta IUD ☐ Hysterectomy ☐ DepoProvera

HPV Vaccine/Gardasil Completed: ☐ Yes ☐ No ☐ 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)

Number of **NEW** sexual partners since last visit: _____ Current Sexual Partner: ☐ Male ☐ Female

Are you currently sexually active? ☐ Yes ☐ No Do you want STD testing? ☐ Yes ☐ No

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

Cologuard: ☐ Yes ☐ No
Date: _____ Result: _____ ☐ Other _____

Colonoscopy: ☐ Yes ☐ No 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