

Women to Women Healthcare Center Confidential Health Inventory

GENERAL INFORMATION:

Date: _____

Name: _____ Age: _____ Birthdate: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP CODE

Mailing Address (if different from above): _____
STREET CITY STATE ZIP CODE

eMail Address : _____

Home #: _____ Cell #: _____ Work #: _____ SSN: _____

Occupation: _____ Employer: _____

Address: _____
STREET CITY STATE ZIP CODE

Employment Status: Full-Time; Part-Time; Student; Retired; Unemployed; Other _____

Living Situation: Alone; Friends(s); Partner; Spouse; Parents; No. of Children: _____
Names and ages of those living with you: _____

Pets: _____

Marital Status: Single; Married; Divorced; Widowed

Name of Partner / Spouse / Parent(s): _____
CIRCLE ONE

Birthdate: _____ SSN: _____ Occupation: _____

Employer: _____ Work Phone No.: _____

Address: _____

In case of emergency, notify: _____ Phone No.: _____

Educational Background: _____ Religious/Spiritual Preferences: _____

How did you hear about the Women to Women Healthcare Center? Phone book; Ad;

Course/Seminar, taught by: _____ Physician/Professional: _____

Articles written by, or referring to: _____ Search Engine: _____

Other: _____

INSURANCE INFORMATION:

Name of Insurance Company: _____

Address: _____
STREET CITY STATE ZIP CODE

Contract No.: _____ Group No.: _____

Other Medical Insurance: _____

FINANCIAL AGREEMENT:

I claim full financial responsibility for services rendered at the Women to Women Healthcare Center for: _____ and understand that payment is required in full at the time of service.

PATIENT NAME

SIGNATURE—PATIENT, OR PARENT OF MINOR

RELATIONSHIP TO PATIENT

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I hereby authorize the release of any medical information necessary in the processing of my claim. I also authorize payment directly to the Women to Women Healthcare Center for surgical/medical benefits.

Date: _____ Signed: _____

SIGNATURE—PATIENT, OR PARENT OF MINOR

INTENTION FOR THIS APPOINTMENT:

ALLERGIES:

Drug Allergies (Penicillin, etc.): _____

Other Allergies (Food, Animals, Pollens, etc.): _____

MEDICAL STATUS:

General Health: Excellent; Good; Fair; Poor

Medications (vitamins, prescriptions, etc.): _____

Have you ever had your cholesterol checked? No; Yes—Date(s)/Results: _____

Have you ever had a mammogram? No; Yes— Date(s)/Results: _____

Do you do self-breast exams? No; Yes— How often? _____

Have you ever had a colonoscopy? No; Yes— Date(s)/Results: _____

Have you ever had a bone density test? No; Yes— Date(s)/Results: _____

HOSPITALIZATIONS/OPERATIONS:

| Date | Hospital | Diagnosis/Operation | Doctor |
|------|----------|---------------------|--------|
|------|----------|---------------------|--------|

PREGNANCIES, including miscarriages & abortions:

| Date | How far along | Sex | Weight | Any Problems? |
|------|---------------|-----|--------|---------------|
|------|---------------|-----|--------|---------------|

CURRENT/RECENT HEALTHCARE PROVIDERS:

| Name | Dates | Care Provided |
|------|-------|---------------|
|------|-------|---------------|

Do any healthcare providers request follow-up on your visit here? No; Yes— Please provide name(s) and address:

OTHER PAST MEDICAL CONDITIONS:

Childhood diseases: German Measles; Chicken Pox; Other: _____
 Heart Trouble: _____; High Blood Pressure; Stroke; Varicose Veins; Phlebitis
 Clotting Defects; Bleeding Tendencies; Blood Transfusion; Diabetes; Kidney Trouble
 Rheumatic Fever; Jaundice/Hepatitis; Epilepsy; Arthritis; Colitis; Asthma;
 Eating Disorder; Chronic Fatigue/Epstein Barr; Fractures: _____; Cancer: _____
 Other: _____

HABITS:

Dietary Preferences/Restrictions: _____

Sample of Daily Menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Routine Physical Exercise: Type: _____ Duration: _____ How often? _____

Tobacco use? No; Yes-- Type: _____ How much? _____ How long? _____

Alcohol use? No; Yes-- How much? _____ How often? _____

Caffeine use? No; Yes-- How much? _____ How often? _____

Other mood altering substance use (i.e. marijuana, cocaine—past and present): _____

STRESSES:

Stresses of family, work, self, etc.: _____

FAMILY HISTORY:

| Member | Living? | Age? | Important Diseases: Cause of Death & Age |
|----------------------|---------|-------|---|
| Mother | _____ | _____ | Alcoholism, High Blood Pressure, Cancer, Diabetes, Heart Disease, Osteoporosis, Other Addictions or Other Illness, please list |
| Father | _____ | _____ | |
| Sister(s) | _____ | _____ | |
| Brother(s) | _____ | _____ | |
| Maternal Grandmother | _____ | _____ | |
| Paternal Grandmother | _____ | _____ | |
| Maternal Grandfather | _____ | _____ | |
| Paternal Grandfather | _____ | _____ | |
| Maternal Aunt(s) | _____ | _____ | |
| Paternal Aunt(s) | _____ | _____ | |
| Maternal Uncle(s) | _____ | _____ | |
| Paternal Uncle(s) | _____ | _____ | |

GYNECOLOGICAL HISTORY:

Date last period began: _____ Date prior period began: _____

Date of last pelvic exam: _____ Date of last pap smear: _____

Were the above normal? _____

Have you ever had an abnormal Pap? No; Yes— When? _____ Results: _____
Treatment: _____

Are you sexually active? No; Yes Do you have intercourse? No; Yes
Do you practice safe sex? No; Yes

Are you trying to get pregnant? No; Yes For how long? _____

Current birth control method: _____ For how long? _____
Any problems? No; Yes: _____

Past birth control methods: _____

Normally (when not on pills), how many days from the start of one period to the start of the next? _____

Number of days of flow: _____ Amount of bleeding: _____ Amount of cramps: _____

Premenstrual syndromes: _____

Starting when? _____

Any changes in your normal pattern? _____

Any bleeding between periods? No; Yes—When? _____

Any unusual pelvic pain, pressure, or fullness? No; Yes—When? _____
Describe: _____

Any unusual vaginal discharge or itching? No; Yes—Describe: _____
For how long? _____ Past treatments: _____

Any sexual concerns to discuss? _____

Any history of tubal infection? _____

Any history of sexually transmitted disease? _____

Any history of DES exposure? _____
(DES was a drug taken by mothers during pregnancy to prevent miscarriage.)

Other information: _____

REVIEW OF SYSTEMS:

Check any symptoms of present significance. (If any past problems, please note under Past Medical Problems, on page 2.)

General Physical

Fever, or Chills; Hot Flashes; Unusual Hair Growth; Skin Eruptions; Weight Changes

Abdomen:

Bloating; Heartburn, Indigestion; Cramps, Pain; Nausea, Vomiting; Hemorrhoids
 Change in Bowel Habits; Bloody, or Tarry Stools; Diarrhea; Constipation; Flatulence

Head:

Headaches; Dizziness; Visual Defects; Hearing Defects; Sinus Trouble; Fainting Spells

Bladder:

Frequent Urination; Painful Urination; Blood in Urine; Inability to Hold Urine;
 Inability to Empty Bladder; Frequent Need to Get Up at Night to Urinate

Chest:

Chest Pain; Shortness of Breath; Heart Murmur; Mitrial Valve Prolapse; Chronic Cough;
 Coughing Up Blood; Wheezing; Palpitations

Breasts:

Lumps; Bleeding; Discharge; Tenderness

Other Comments or Concerns: _____

Women to Women Healthcare Center

Daily Living Profile

Name: _____ DOB: _____ Date: _____

Please read the following statements, which relate to your current life at home and work, and indicate whether each statement does, or does not describe part of your current life by placing an "X" in the "Yes" or "No" box at the right of the statement. This questionnaire is designed to increase your awareness of your lifestyle and stresses on your physical well-being.

Neighborhood Stresses:

1. My neighborhood is too noisy Yes No
2. My neighborhood is too crowded Yes No
3. My neighborhood is too quiet Yes No
4. I do not have enough friends/neighbors..... Yes No
5. I live in a dangerous neighborhood..... Yes No
6. Having so many household tasks irritates me..... Yes No
7. The weather here bothers me..... Yes No
8. I am new to this area..... Yes No
9. Other neighborhood problems..... Yes No

If "Yes," please describe: _____

Family Stresses:

10. I recently married..... Yes No
11. I recently divorced, or separated..... Yes No
12. I recently moved, or am planning to move..... Yes No
13. I am alone too much at home..... Yes No
14. I am concerned about my relationship with my partner..... Yes No
15. I am concerned about my relationship with another family member..... Yes No
16. I feel I was raised in a dysfunctional environment..... Yes No
17. There is a new baby in our family..... Yes No
18. I, or one of my family members, is having legal problems..... Yes No
19. There was a recent death of a family member, or close friend..... Yes No
20. There is serious illness in my family..... Yes No
21. I am worried about one of my family members, or close friends..... Yes No
22. Someone close to me drinks too much..... Yes No
23. One of my children has moved away from home recently..... Yes No
24. I, or my partner, have recently retired..... Yes No
25. Other family, or household problems..... Yes No

If "Yes," please describe: _____

Work Stresses:

- 26. I am bored with the work I do..... Yes No
- 27. Other people make too many demands of me..... Yes No
- 28. I have too little control over my own work..... Yes No
- 29. I am not satisfied with the work I do..... Yes No
- 30. I often feel over whelmed by my responsibilities..... Yes No
- 31. There is not enough time to finish my work..... Yes No
- 32. I just began a new job..... Yes No
- 33. I just lost my job..... Yes No
- 34. I don't get along with my boss/co-workers..... Yes No
- 35. I am having problems with the people I work with..... Yes No
- 36. Other work-related problems..... Yes No

"Yes," please describe: _____

Personal Stresses:

- 37. I worry about money a great deal..... Yes No
- 38. I feel lonely..... Yes No
- 39. I am bored with my life..... Yes No
- 40. I am generally concerned about my health..... Yes No
- 41. I think a lot about dying..... Yes No
- 42. I have particular concerns relating to my religion..... Yes No
- 43. Other personal problems..... Yes No

"Yes," please describe: _____

Stress Effects:

- 44. I have difficulty falling asleep..... Yes No
- 45. I have difficulty staying asleep..... Yes No
- 46. I have difficulty staying awake..... Yes No
- 47. I feel tired when I wake up in the mornings..... Yes No
- 48. I feel nervous most of the time..... Yes No
- 49. I often feel depressed..... Yes No
- 50. I worry a lot..... Yes No
- 51. I am frequently ill..... Yes No
- 52. I have considered committing suicide..... Yes No
- 53. I have some sexual problems..... Yes No
- 54. I sometimes feel weak, or light-headed..... Yes No
- 55. I often have pains in my shoulders, neck, or back..... Yes No
- 56. I often feel like crying..... Yes No

