Please mail your information to:

Women to Women Healthcare Center
3 Marina Road
Yarmouth, ME 04096

Or, you may fax your information to:

Women to Women Healthcare Center
Fax# 207-846-6167

women to women

Healthcare Center

Helping women to heal themselves

Marcelle Pick, R.N.C., M.S.N., OB/GYN N.P.
Carrie E. Levine, C.N.M., M.S.N.
Catherine G. Gaynor, F.N.P. - C.

Comprehensive & advanced woman-to-woman care for total health & well-being.

- Annual pelvic & breast exams
- Treatment of pelvic pain, abnormal bleeding, endometriosis, ovarian cysts, fibroids, vaginal infections & abnormal Pap smears
- Menopause counseling
- Natural hormone testing & treatment
- Self-empowerment coaching
- Herbal solutions
- Nutrition advice
- Supplementation education
- Alternatives to hysterectomy
- Colposcopy
- Cryocautery

3 Marina Road
Yarmouth, ME 04096
(207) 846-6163
Fax: (207) 846-6167
www.womentowomen.com

WELCOME TO THE WOMEN TO WOMEN HEALTHCARE CENTER

We are pleased to be participating with you on your journey to optimum health. Our goal is to share with you our expertise in providing comprehensive and advanced "women to women" care for your total health and well-being.

The health inventory form will assist your provider in learning about who you are and what your current concerns may be.

Please include the following:

1) A brief note explaining your concerns.

2) A copy of any recent blood work, pap reports, pathology, x-ray or ultrasound reports.

3) A copy of any recent office visit notes from your other medical providers.

PLEASE DO NOT INCLUDE ANY RECORDS MORE THAN TWO YEARS OLD, OR X-RAY FILMS.

At *Women to Women*, we allow ample time to address your needs. Your initial visit could last from 1-2 hours (combined time spent with nurse, practitioner, and our patient educator). The charge generally ranges from $250-$450, plus fees for any lab work. Outside labs submit their own bills for processing the tests that we forward to them, inlcuding paps, bloodwork, and cultures.

Please extend to us the courtesy of calling 2 business days in advance if you need to change your appointment. Our office maintains a waiting list for these cancellations. The $50 cancellation fee is waived for those patients who call 2 business days prior to their visit.

Directions to *Women to Women* are located on our website at: **http://www.womentowomen.com/clinic**

We look forward to meeting you!

Women to Women Heathcare 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: Alcoholism, High Blood Pressure, Cancer, Diabetes, Heart Disease, Osteoporosis, Other Addictions or Other Illness, please list	Cause of Death & Age
Mother				
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

57. I drink too much coffee..... ❒ Yes ❒ No
58. I smoke too much..... ❒ Yes ❒ No
59. I often drink too much alcohol..... ❒ Yes ❒ No
60. I eat much more than I used to..... ❒ Yes ❒ No
61. I eat much less than I used to..... ❒ Yes ❒ No
62. I am concerned about my weight..... ❒ Yes ❒ No
63. I lose my temper more than I use to..... ❒ Yes ❒ No
64. I think that I might be helped by counseling..... ❒ Yes ❒ No
65. Other stress-related problems..... ❒ Yes ❒ No

"Yes," please describe: _____

_____

66. Do you have any personal matters you wish to discuss with your practitioner? ❒ Yes ❒ No

Please use this space to add any other information about yourself that you think will be of help to us.

_____

_____

_____

_____

_____

_____

_____

_____

_____

And, lastly, please circle the answers to any statements, or concerns that bother you a great deal.

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Healthcare Center

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themselves

3 MARINA ROAD YARMOUTH, ME 04096
PH: (207) 846-6163 FX: (207) 846-6167

MEDICAL SYMPTOMS QUESTIONNAIRE

Name: _____ **Date:** _____

Rate each of the following symptoms based upon your typical health profile for:
❒ Past 48 hours ❒ Past 30 days

Point Scale:
0- Never, or almost never have the symptom
1- Occasionally have it, effect is <u>not</u> severe
2- Occasionally have it, effect is severe
3- Frequently have it, effect is <u>not</u> severe
4- Frequently have it, effect is severe

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total: _____
EYES	_____	Watery, or Itchy eyes	
	_____	Swollen, reddened, or sticky eyes	
	_____	Blurred, or tunnel vision(does not include near, or far-sightedness)	
	_____	Bags, or dark circles under eyes	
			Total: _____
EARS			
	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	
			Total: _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	
			Total: _____
MOUTH/THROAT			
	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen, or discolored tongue, gums, lips	
	_____	Canker sores	
			Total: _____
SKIN			
	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total: _____
HEART			
	_____	Irregular, or skipped heartbeat	
	_____	Rapid, or pounding heartbeat	
	_____	Chest pain	Total: _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	Total: _____

DIGESTIVE TRACT

_____	Nausea, vomiting	
_____	Diarrhea	
_____	Constipation	
_____	Bloated feeling	
_____	Belching, passing gas	
_____	Heartburn	
_____	Intestinal/stomach pain	Total: _____

JOINTS/MUSCLE

_____	Pain, or aches in joints	
_____	Arthritis	
_____	Stiffness or limitation of movement	
_____	Pain, or aches in muscles	
_____	Feeling of weakness, or tiredness	
		Total: _____

WEIGHT

_____	Binge eating/drinking	
_____	Craving certain foods	
_____	Excessive weight	
_____	Compulsive eating	
_____	Water retention	
_____	Underweight	Total: _____

ENERGY/ACTIVITY

_____	Fatigue, sluggishness	
_____	Apathy, lethargy	
_____	Hyperactivity	
_____	Restlessness	Total: _____

MIND

_____	Poor memory	
_____	Confusion, poor comprehension	
_____	Poor concentration	
_____	Poor physical coordination	
_____	Difficulty in making decisions	
_____	Stuttering, or stammering	
_____	Slurred speech	
_____	Learning disabilities	Total: _____

EMOTIONS

_____	Mood swings	
_____	Anxiety, fear, nervousness	
_____	Anger, irritability, aggressiveness	
_____	Depression	
_____	Thinking about past	
_____	Poor self-esteem	
_____	No time for yourself	
_____	Feeling of isolation	
_____	Always feel like it is your fault	
_____	Things never go your way	Total: _____

OTHER

_____	Frequent illness	
_____	Frequent or urgent urination	
_____	Genital itch or discharge	
		Total: _____

GRAND TOTAL: _____

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MEDICATION LOG

Please list all current medications

Medications	Directions						

Patient Name: _____ DOB:_____

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SUPPLEMENT LOG

Please list all current supplements and vitamins

Supplements	Directions						

Patient Name: _____ DOB:_____