CARING CENTER FOR WOMEN, PA
OF SAN MARCOS – NEW BRAUNFELS

PATIENT INFORMATION

DATE: _____

ALL THE INFORMATION REQUESTED ON THIS PAGE IS NEEDED SO THAT WE CAN PROVIDE YOU WITH THE BEST POSSIBLE CARE. PLEASE COMPLETE EACH PART OF THIS FORM SO THAT WE CAN HAVE CURRENT INFORMATION.

PATIENT NAME: _____ AGE: _____

ADDRESS: _____ CITY/ST/ZIP: _____

BILLING ADDRESS: _____ CITY/ST/ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____

DATE OF BIRTH: _____ MARITAL STAUS: ☐ S ☐ M ☐ W ☐ D

EMPLOYER: _____ EMAIL ADDRESS: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE: _____

RACE:
Please check one of the following
- ☐ Decline
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other Race

ETHNIC GROUP:
Please check one of the following
- ☐ Decline
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

My Insurance requires me to use: _____ lab. (_____) Initials

PHARMACY: _____ LOCATION: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE #: _____

CITY/ST/ZIP: _____ INSURED'S SS#: _____

IN CASE OF EMERGENCY, NOTIFY:

NAME: _____ PHONE #: _____

RELATIONSHIP _____

FAMILY PHYSICIAN: _____ SPECIALIST PHYSICIAN: _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I acknowledge that Caring Center for Women, PA provided me with a written copy of the Notice of Health Information Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

PATIENT FINANCIAL RESPONSIBILITY POLICY

I acknowledge that Caring Center For Women, PA provided me with a written copy of the Patient Financial Responsibility policy and I have read, understand and agree to all provisions outlined. I hereby give my consent for Caring Center For Women, PA to file Insurance claims on my behalf. I also certify the information given by me regarding claims filed on my behalf to a Commercial Insurance is correct.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

ADVANCE PRACTICE NURSE

Caring Center For Women, PA has on staff an advance practice nurse to assist in OB/GYN care. An advance nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs. I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

_____ _____

Patient Signature Date

Please list any individual who will be allowed to make inquiries about your health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we contact you at home?	☐ Yes	☐ No	May we leave a message?	☐ Yes	☐ No
May we contact you on your cell phone?	☐ Yes	☐ No	May we leave a message?	☐ Yes	☐ No
May we contact you at work?	☐ Yes	☐ No	May we leave a message?	☐ Yes	☐ No

Person(s) we may leave message with at home, on cell phone or at work: _____

_____

_____ _____

Patient Signature Date

CARING CENTER FOR WOMEN, PA

NAME: _____

(Please Check Current Problems)

Constitutional
- ☐ chills
- ☐ fatigue
- ☐ fever
- ☐ victim-domestic violence
- ☐ weight gain (unintentional)
- ☐ weight loss (unintentional)

Gastrointestional
- ☐ abdominal pain
- ☐ acid reflux
- ☐ lack of appetite
- ☐ bloating
- ☐ difficulty swallowing
- ☐ clay-colored stool
- ☐ constipation
- ☐ diarrhea
- ☐ heartburn
- ☐ vomiting blood
- ☐ blood in stool
- ☐ hemorrhoids
- ☐ leaking stools
- ☐ dark, tarry stools
- ☐ nausea
- ☐ vomiting
- ☐ stool caliber change

Genitourinary
- ☐ painful periods
- ☐ painful sex
- ☐ pain with urination
- ☐ decreased sex drive
- ☐ orgasm dysfunction
- ☐ high risk sexual behavior
- ☐ irregular menstrual cycle
- ☐ very heavy periods
- ☐ frequent bladder infections
- ☐ blood in urine
- ☐ frequent urination at night
- ☐ frequent urination
- ☐ leaking urine
- ☐ bleeding after sex
- ☐ bleeding after menopause
- ☐ rape (history of)
- ☐ sexual abuse
- ☐ frequent vaginal infections
- ☐ genital sores/bumps
- ☐ vaginal discharge
- ☐ vaginal itching

Integumentary Breast
- ☐ moles changing in appearance
- ☐ yellow colored skin/eyes
- ☐ chronic itching
- ☐ rashes
- ☐ breast mass
- ☐ breast skin changes
- ☐ breast tenderness
- ☐ nipple discharge

Endocrine
- ☐ hair loss
- ☐ heat/cold intolerance
- ☐ sweating, excessive
- ☐ abnormal hair growth
- ☐ darkening skin
- ☐ excessive thirst
- ☐ excessive hunger
- ☐ infertility
- ☐ hot flashes
- ☐ vaginal dryness
- ☐ night sweats

Psychiatric
- ☐ anxiety
- ☐ crying spells
- ☐ depression
- ☐ feeling stressed
- ☐ loss of interest in pleasurable activities
- ☐ mood swings
- ☐ personality change
- ☐ PMS (premenstrual tension)
- ☐ poor concentration
- ☐ recreational drug use
- ☐ sadness
- ☐ sleep disturbance
- ☐ suicidal thoughts

****** TURN PAGE OVER ******

Thank you for filling this out. If the question does not apply to you, please skip it or put NA in the blank.

Do you have monthly periods? Y N **Menopausal?** Y N If "Y", since when? _____

First day of last two (2) menstrual periods? _____ _____

Are you sexually active? Y N **With** (please circle)? Men Women Both

How long have you been with your current partner? _____ **How many partners in the past year?** _____

Type of birth control used:

Abstinence Natural Family Planning Condoms IUD (Mirena or Paragard) Implanon/Nexplanon

DepoProvera Nuva Ring Tubal Ligation Essure Vasectomy

Diaphragm Hysterectomy Birth control pill (name) _____

Do you smoke? Y N If "Y", how much? _____

Do you take any of the following supplements?

Fish Oil (omega3 fatty acids) Multivitamins Prenatal vitamins Calcium Vitamin D

Do you exercise? Y N If "Y", what type of exercise? _____

How many minutes? _____ How many days a week? _____

Do you perform self-breast exams? Y N If "Y", when? Monthly Occasionally

When was your last Pap Smear? _____ **Have you ever had an abnormal pap?** **Y** **N**

If "Y", when? _____ Did you receive treatment? Colposcopy/biopsy LEEP/cone Cryotherapy

Have you had an STD? Y N

Chlamydia Gonorrhea Herpes Syphilis Trichomonas HIV Hepatitis HPV/genital warts

Have you had a mammogram? Y N **Have you had an abnormal mammogram?** Y N

If you have had an abnormal mammogram, when was this imaging study taken? _____

Have you had screening blood test within the past year? Y N **If "Y":** Cholesterol ☐ Thyroid ☐ Blood sugar ☐

Have you had the: Gardasil (HPV) vaccine Y N **Is your tetanus vaccine current?** Y N

Have you had:

Colonoscopy or sigmoidoscopy? Y N If "Y", when? _____ Results? _____

Bone Density Study? Y N If "Y", when? _____ Results? _____

In the past year, has your partner shoved, slapped, choked, hit or pushed you? Y N

In the past year, has your partner threatened you, your friends/family, pets or property? Y N

Do you have any specific concerns you want addressed today? _____

_____

_____

_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Height: _____ **Weight:** _____ **Age of First Period:** _____ **Your Age at Delivery of First Child (if applicable):** _____
Are You Menopausal: Yes or No **Have you ever used Hormone Replacement Therapy?** Yes or No
Has anyone in your family had genetic testing for a hereditary cancer syndrome (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65 yrs*
Y	N	Breast cancer (including DCIS)				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish descent?				

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate Cancer (BRCA)				
Y	N	Pancreatic Cancer (Col/BRCA)				
Y	N	Melanoma (BRCA)				

Patient's Signature: _____ Date: _____

For Office Use Only:
BRCA/Lynch Testing Indicated?: YES NO
Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED
Follow-up appointment scheduled: YES NO Date of Appointment: _____

MD Signature: _____ Date: _____

BRCA – Personal or Fam. History	BRCA – Personal or Fam. History	Lynch Syndrome (Colon/Endo)
One person with (out to 2nd degree) • Breast Cancer at 45 or younger • Ovarian Cancer at any age • Male breast cancer any age • Breast Cancer + Jewish Heritage • Bilateral Breast at 50 or younger • Triple Neg Br.Ca. at 60 or younger	Two persons with (out to 3rd Degree) • 2 Breast Cancers, w 1 ≤ 50 or younger • Breast & Ovarian (any age) Three Persons with (out to 3rd degree) • Breast and/or Ovarian and/or Pancreatic (any age)/aggressive Prostate	Personally affected with: • Colon or Endometrial at ≤ 50 or younger Family History of Colon, Endometrial, + another Lynch Cancer (out to 2nd degree) (gastric, ovarian, brain, kidney, small bowel) • 2 or more Lynch cancers, 1 dx ≤ 50

CARING CENTER FOR WOMEN PA

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San Marcos, Texas 78666-7541

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New Braunfels, Texas 78130

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Fax (512) 396-7555

Dear Patient,

Welcome to Caring Center For Women, PA. We are pleased you have selected our practice for your health care needs. Our doctors and staff are committed to providing you the highest quality service in a pleasant environment.

Physical Exams: Typically a physical exam is an annual checkup your physician uses to assess your overall health. Your physical exam benefits will cover this checkup usually without a copay. Please note, if you arrive at your annual exam with other issues that need to be discussed, such as but not limited to irregular bleeding, menopausal symptoms or other illnesses, that visit is now considered a standard physician's office visit for which a copayment and/or other applicable benefits such as deductible or co-insurance will be applied by your insurance. It is a convenience to many patients to have these "illness concerns" discussed at the time of a "well woman" visit, but copays may now apply.

One type of Physical Exam is the Well-Woman visit. At a well-woman visit, the patient sees her Provider for an annual checkup with or without an annual pelvic exam. Please note that if you have your pelvic exam or physical done with another provider within one (1) year, your insurance may not cover a physical with our office. Pelvic exam, pap smear, and a clinical breast exam are regular, important, and recommended preventative services for women and is covered once per calendar year.

Annual physical examinations are the foundation for wellness, health promotion, and disease identification and management throughout your life. It is no secret that healthy living and early detection of disease increases not only your length of life but, more importantly, your quality of living. A periodic annual exam for all ages is not just about good medical care, but it also gives you the opportunity to learn more about beneficial health habits, counseling and community support services, as well as an overall view of the best ways to take care of yourself and your family for a lifetime.

The annual physical exam basically is performed in four (4) parts:

- The health history is complete and includes family medical history, past medical and surgical history, current medications, social history, habits, and allergies. If you are establishing care with a new healthcare professional, your first visit may be longer and more involved than later office visits. Since your healthcare provider is not familiar with you, a detailed medical family, obstetric, gynecologic, genetic and psychosocial history is done to develop a complete plan of care. It is important to know your family medical and

(turn page over)

genetic history. It always is a good idea to bring any medical records and a list of medications that you are already taking, including alternative treatments such as herbal preparations to your first health visit.

- The review of body systems is performed, as well as an assessment for other potential future health problems.

- A physical includes taking your vitals and a comprehensive exam that may give clues to any health problems. Urine testing and lab work may be ordered depending on the needs of the individual patient. Your healthcare provider likely will examine eyes, ears, nose, mouth, thyroid gland, lungs, lymph nodes, heart, breasts, abdomen, reflexes, skin, bones, and spine. Any problems that are noted may result in a referral to another healthcare provider. Eye and dental care is a must for overall health, too, and you should seek routine care for these health issues.

- Creation of a plan of recommendations, counseling on a variety of related areas, and possible referral for future preventive care is administered, as recommended by standard of care measures.

I have read and fully understand what this office considers a well exam. I also understand other services provided outside this scope of the well exam, which are done to achieve a high standard of care and/or to avoid another visit to the office, may be subject to a copay, deductible, and/or coinsurance.

Patient Name: _____ DOB: _____
(Signature)

DATE: _____