Caring Center For Women
New Patient Medical History

Patient Name: _____ DOB: _____ Date: _____

Reason for today's visit: _____

Referring Physician/Clinic: _____
Primary Care Physician: _____ Other specialists: _____

Pharmacy (name, address, phone number) : _____

Drug Allergies: _____

Current Medications

Name of Medication	Strength and Dose	What do you take this for?	Doctor who prescribed

Gynecologic History

Do you still have periods? **Yes** **No** Are you postmenopausal? **Yes** **No**

Have you had a hysterectomy? **Yes** **No** If yes, why did you have a hysterectomy? _____

Do you still have ovaries? **Yes** **No** **Unsure** Have you had an endometrial ablation? **Yes** **No**

1st Day of Last Menstrual Period: _____ Age at Menarche (age at 1st period): _____

How often are your periods? **Once a month** **Irregular periods** **Absent (No) periods**

How many days does your period last? _____ Periods are: **Light** **Moderate** **Heavy**

Approximate # pads/tampons used per day on your heaviest day: _____ Do you have painful periods? _____

Cramps are: **Mild** **Moderate** **Heavy** Do you take medication for your periods? _____

Age at Menopause: _____ Have you used hormones after menopause? **Never** **Past use** **Current use**

Current Birth Control Method(s): _____

Do you have a **personal** history of: **Endometriosis** **Uterine fibroids** **Infertility** **Ovarian Problems** **PCOS**

Date of last mammogram: _____ History of abnormal mammogram: **Yes** **No**

Do you have a personal history of breast cancer? **Yes** **No** If yes, give details: _____

Patient Name: _____ DOB: _____

Gynecologic History- continued

Date of last colonoscopy: _____ **Normal** **Abnormal**

Date of last bone density: _____ **Normal** **Osteopenia** **Osteoporosis**

Date of last Pap Smear: _____ History of abnormal pap? **Yes** **No** **Date:** _____

Tested for HPV: **Yes** **No** Positive test for HPV: **Yes** **No**

Did you receive HPV Vaccines: **Yes** **No** Did you complete the full series? **Yes** **No** **Unsure**

History of Cervical Dysplasia: **Yes** **No** History of DES (Diethylstilbestrol) exposure: **Yes** **No**

Have you had treatment for abnormal pap? Yes No If yes, please give the date _____

Circle the treatments you have had for abnormal pap:

Colposcopy **LEEP** **Cervical Conization** **Other** _____

Have you ever been sexually active? **No** **Yes** Age at 1st intercourse:_____ Total Lifetime Partners: ____

Sexual Orientation: **Heterosexual** **Homosexual** **Bi-sexual** **Transgender**

Are you currently sexually active? **Yes** **No** How many partners have you had in the past year? _____

Have you had a STI (Sexually Transmitted Infection)? **Yes** **No** Name and date of STI:_____

Would you like to be tested for STI today? **Yes** **No**

Obstetric History

Pregnancies _____ Full-term deliveries _____ Preterm deliveries _____

Miscarriages _____ Abortions _____ Living children _____

Please list details of all pregnancies (including abortions, deliveries, ectopic, miscarriages, and still-births) below.

Date M/D/Y	Sex M/F	Baby's Name	Length of labor	Type of delivery	Epidural? Yes/No	Gest. Age in wks (40 = fullterm)	Place of delivery	COMPLICATIONS

Patient Name: _____ DOB: _____

Family Medical History

Disease	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Other: Aunt, Uncle, etc.
Blood Coagulation Disorder/clots									
Cancer (specify type)									
Diabetes									
Genetic/Hereditary Disease									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Lung Disease									
Hypothyroidism									
Hyperthyroidism									
Psychiatric/ Mental Illness									
Other									

SOCIAL HISTORY

Smoking status: **Never** **Former** **Current Daily Smoker** **Current Some Days Smoker** **Tobacco # years**_____

How much? PPW: **1** **2** PPD: **¼** **½** **1** **1 ½** **2** **3+**

Alcohol intake: **None** **Occasional** **Moderate** **Heavy**

How many days in the past year have you had a heavy drinking consumption (Heavy = 4+/day) _____

Illicit drugs: **Never** **Current** **Past** **Details:** _____

Caffeine intake: **None** **Occasional** **Mod.** **Heavy** Exercise level: **None** **Occasional** **Mod.** **Heavy**

Diet: **Regular** **Vegetarian** **Vegan** **Gluten Free** **Carbohydrate** **Cardiac** **Diabetic** **Other** ____

Marital status: **Single** **Married** **Divorced** **Widowed** **Domestic Partner** **Separated**

History of domestic violence: **Yes** **No**

Education: Highest grade you completed in school: _____**Grade** **Undergraduate Degree** **Post graduate degree**

Occupation: _____ Would you like to list a religion? _____

Seat belts used routinely: **Yes** **No** Is a blood transfusion acceptable in an emergency? **Yes** **No**

Have you recently (the last 12 weeks, or during a current pregnancy) traveled to or lived in a zika-affected area? _____

Do you have symptoms associated with zika virus (fever, rash, joint pain, or conjunctivitis)? **Yes** **No**

Patient Name: _____ DOB: _____

Personal Medical History

CANCER		
Breast Cancer	Y	N
Cervical Cancer	Y	N
Colon Cancer	Y	N
Endometrial/Uterine Cancer	Y	N
Cancer – Genetic Screening	Y	N
Lung Cancer	Y	N
Ovarian Cancer	Y	N
Skin Cancer	Y	N
Vulvar/Vaginal Cancer	Y	N
Other Cancer	Y	N
CARDIAC		
Aneurysm	Y	N
Heart Arrhythmia		
Heart Attack	Y	N
Heart Disease	Y	N
Heart Murmur	Y	N
Mitral Valve Prolapse	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Other Cardiology Problem	Y	N
DERMATOLOGY		
Acne	Y	N
Eczema/Psoriasis	Y	N
Other Dermatology	Y	N
ENT		
Hearing Loss	Y	N
Seasonal Allergies	Y	N
Other ENT Problem	Y	N
ENDOCRINOLOGY		
Diabetes	Y	N
Glucose Intolerance	Y	N
Insulin Resistance	Y	N
Gestational Diabetes	Y	N
Hyperthyroidism	Y	N
Hypothyroidism	Y	N
Osteopenia	Y	N
Osteoporosis	Y	N
Prolactinoma	Y	N
Vitamin Deficiency	Y	N
Other Endocrinology Problem	Y	N

EYES		
Glaucoma	Y	N
Vision Loss	Y	N
Other Eye Problem	Y	N
GASTROENTEROLOGY		
Colon Polyps	Y	N
Chron's/Ulcerative Colitis	Y	N
Gallbladder Disease	Y	N
Hemorrhoids	Y	N
Irritable Bowel Syndrome	Y	N
Liver Disease/Hepatitis	Y	N
Reflux/Ulcers	Y	N
Other GI Problem	Y	N
GYNECOLOGY		
Endometriosis	Y	N
Uterine Fibroids	Y	N
Infertility	Y	N
PCOS	Y	N
Other Gynecologic Problem	Y	N
HEMATOLOGY		
Anemia	Y	N
Bleeding Disorder	Y	N
Blood Clotting Disorder	Y	N
Blood Transfusion	Y	N
DVT/Pulmonary Embolism	Y	N
Other Hematology Problem	Y	N
INFECTIOUS DISEASE		
Tuberculosis/Positive PPD	Y	N
Chicken Pox/Shingles	Y	N
HIV	Y	N
MRSA	Y	N
Other Infectious Disease	Y	N
RENAL (KIDNEY)		
Renal Disease	Y	N
NEUROLOGY		
Dementia	Y	N
Headaches/Migraines	Y	N
Multiple Sclerosis	Y	N
Seizures/Epilepsy	Y	N
Stroke/TIA	Y	N
Other Neurology Problem	Y	N

Patient Name: _____ DOB: _____

ORTHO

Arthritis	Y	N
Chronic Back Pain	Y	N
Fractures	Y	N
Other Orthopedic Problem	Y	N

PSCHIATRIC

ADD	Y	N
Anxiety Disorder	Y	N
Bipolar Disorder	Y	N
Depression	Y	N
Eating Disorder	Y	N
PMS/PMDD	Y	N
Other Psychiatric Problem	Y	N

PULMONOLOGY (LUNG)

Asthma	Y	N
COPD/Emphysema	Y	N
Sleep Apnea	Y	N
Other Pulmonary Problem	Y	N

RHEUMATOLOGY

Arthritis	Y	N
Autoimmune Disease	Y	N
Fibromyalgia/Chronic Pain	Y	N
Other Rheumatology Problem	Y	N

UROLOGY

Hematuria (Blood in urine)	Y	N
Interstitial Cystitis	Y	N
Recurrent UTIs	Y	N
Stones	Y	N
Urinary Incontinence	Y	N
Other Urology Problem	Y	N

WEIGHT MANAGEMENT

Obesity	Y	N
Weight Loss Surgery	y	N
Other Weight Management	Y	N

Surgical History

Please list all surgeries with date and the reason done.

Surgery	Date Performed	Reason for Surgery	Doctor

Please list any additional information regarding your medical history:

_____

_____

_____

_____

_____

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 ******

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

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: _____ ZIP: _____

BILLING ADDRESS: _____ ZIP: _____

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

(Please check the box for your Preferred Contact #)

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

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: _____

TURN PAGE OVER

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 on advance practice nurse to assist in OB/GYN care. An advance nurse is not a doctor. And 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
May we leave a detailed message on your voicemail? ☐ Yes ☐ No

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

_____

_____ _____
Patient Signature Date