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 <u>personal</u> 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

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Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ **Date of Birth:** ____________ **Age:** __________
Height: ________ **Weight:** ________ **Age of First Period:** ________ **Age 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				
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 at 50 or younger • Breast & Ovarian (any age) Three Persons with (out to 3rd degree) • Breast and/or Ovarian and/or Pancreatic (any age)	Personally affected with. • Colon or Endometrial at ≤ 50 or younger Family History of Colon, Endometrial. + another Lynch Cancer (gastric, ovarian, brain, kidney, small bowel) • 2 or more Lynch cancers, 1 dx ≤ 50

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: ____________________

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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 ____________

1305 Wonder World Drive, Suite 203
San Marcos, Texas 78666-7541

705 Generations Drive, Ste 101
New Braunfels, Texas 78130

Phone (830)387-4790
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

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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: __________________________________