



The Women's Center pllc

12301 NE 10th Place, Suite 100

Bellevue, WA 98005

425-827-0100

PATIENT INFORMATION

Welcome! We thank you for completing the following information.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

(1) Home Phone: _____

(2) Work Phone: _____

(3) Cell Phone: _____

(4) Email address: _____

May we leave appointment information? Circle if yes: 1 2 3 4 May we leave medical information? Circle if yes: 1 2 3 4

Is there anyone else with whom we can discuss your medical information?

If yes: _____ Relationship: _____

Spouse/partner Name: _____ Employer: _____

Emergency Contact: _____ Telephone: _____

Your social security number: _____

Date of birth: _____ Age: _____ Marital Status: _____

Name of insured: _____ Relationship: _____

Social Sec # _____ Date of birth: _____

Insurance company: _____

Group # _____ Policy # _____

We will require a copy of your insurance card at the time of your visit.

How did you hear about us? _____

Thank you.

I have been offered a copy of the HIPAA Disclosure Statement for this office.

Signed: _____

I hereby give The Women's Center pllc and its associate's permission for evaluation and treatment of myself.

Signed: _____

I understand that I am responsible for financial payments and insurance issues with this office. Services rendered that are not covered by my insurance contract are my responsibility. I understand that I am responsible for copayments and amounts to reach my deductible at the time of service. I agree to pay interest on overdue accounts. I agree that, should my account be sent to collections or legal actions are pursued, all additional costs are my responsibility.

Signed: _____ Date: _____

NEW PATIENT – HEALTH INFORMATION

This information is very valuable in assisting us in a thorough evaluation of your health.
Please fill it out as completely as possible.

Name: _____ Age: _____

Reason for Visit: _____

Medical History:

Allergies: _____

Current Medications: _____

Medical Issues: _____

Previous Surgeries: _____

Family History: (cancer, diabetes, etc) of parents, children, siblings: _____

Do you smoke? _____ If yes, how much? _____ For how long? _____

Do you drink alcohol? _____ What kind and how many times a week? _____

Do you use recreational drugs? _____ Type and amount: _____

Do you use supplements or herbs? _____ What kind and how often? _____

Female History:

Age of first menstruation: _____ First day of last menstrual period: _____

Pregnancies:

How many? _____ Miscarriages? _____ Elective Terminations? _____ Live births? _____

Cesarian sections? _____ Problems with pregnancy? _____

How many days elapse between the first day of one cycle and the first day of the next cycle? _____

Usually regular? _____

If not, describe: _____

Flow how many days? _____ Heavy how many days? _____ How many pads/tampons used on a heavy day? _____

Before and during cycles:

Mood changes? _____ Cramps? _____ Other _____

Do you take any medications/herbs/vitamins to help with the above? _____

Concerns about cycles? _____

Do you have spotting between cycles or after intercourse? _____

Do you have pain with intercourse? _____

Pap Smear History:

Date of last pap smear: _____

_____ Always regular and normal results

_____ Somewhat abnormal years ago, but normal for the last 3 years

_____ Told I have HPV (human papilloma virus)

Abnormal history-please describe: _____

Urinary History:

Please check all that apply:

- No concerns
- Leak with cough/activity
- Rare leakage
- Leak with intercourse
- Pain with urination
- Leak uncontrolled and unpredictable
- Flank pain
- Incomplete emptying
- Urinate more than two times in the night
- Feeling "something is falling"

Contraception:

- None Rhythm Evra Patch
- Condoms Depo injection Mirena IUD
- 'Tubes tied' Vasectomy IUD (paragard/copper T)
- Birth control pills Type: _____

Types of birth control tried and didn't like: _____

Breast Health:

- Last mammogram date: _____ Normal?
- Do you have or have you had breast cancer?
- Do you have a mother, sisters, or daughters with breast cancer? _____
- Do you have a family history of colon or ovarian cancer? _____

Sexual Health:

- Age of first intercourse: _____ Lifelong number of partners: _____
- Have you been sexually abused?
- History of any of the following: Chlamydia, condyloma, herpes, hepatitis, gonorrhea, trichomonas, HIV: Please list type and year: _____
- Have you ever had PID (pelvic inflammatory disease)? _____
- Are you satisfied with your sexuality or? _____

Osteoporosis Screening:

- Are you: Caucasian? Asian? Thin bone frame?
- Are you taking any medication that can affect your bones? _____
- Any unexplained fractures?
- Family members with osteoporosis? _____
- Do you drink lots of soda or coffee?
- Do you maintain adequate calcium, Vitamin D and magnesium in your diet? _____

Nutrition:

List breakfast Monday-Friday: _____
Snack and drink: _____
Lunch Monday-Friday: _____
PM snack and drink: _____
Dinner Monday-Friday: _____
After dinner eating: _____

Exercise

Count everything: _____
Frequency: _____

Psychological

Emotional illness: _____
Depression: _____
Excessive worry or anxiety: _____
Severe tension: _____
Feelings or worthlessness, loneliness: _____
Do you have: Please detail. _____
Anxiety issues? _____
Eating issues? _____
Mood issues? _____
Sleep issues? _____

Review of Systems:

Please circle current concerns:

- Constitutional:** chills, fatigue, fever, night sweats, unintentional weight loss or gain
- Cardiovascular:** chest pain, dizziness, palpitations, racing heart
- Respiratory:** cough, shortness of breath, wheeze
- Gastrointestinal:** Abdominal pain, acid reflux, anorexia, bloating, constipation, diarrhea, blood in stool, hemorrhoids, stool caliber change, black stool
- Allergic:** seasonal, bee sting
- Musculoskeletal:** joint aches, low back pain, limb pain, muscle pain
- Skin:** atypical moles, rash
- Neurological:** Fainting, headaches, memory loss, tingling, seizures, tremors, weakness
- Blood:** easy bruising, excessive bleeding
- Endocrine:** Hair loss, heat/cold intolerance, hairiness, hot flashes, increased skin pigmentation, infertility, excessive thirst
- Psychiatric:** Poor concentration, suicidal thoughts, anxiety

Thank you and welcome to a new approach to your health care.

Please visit our website for links to high quality educational information on women’s health.