Ann M. Hentzen Page, MD, FACOG

The Woman's Place HEALTHCARE FOR WOMEN

Kathryn E. Sawchak, MD, FACOG

1818 E. 23rd Ave. Hutchinson, KS 67502 620.662.2229 888.862.2224 www.thewomansplace.net

Visit Date: _____ Patient Chart: _____

Patient Name: _____ _____ _____ SS#:_____
(First) (MI) (Last)

Date of Birth: _____Age: _____ Sex: _____ Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Home Address: _____ P.O. Box: _____

City.:_____ State:_____ Zip Code: _____

Home Phone:( ) _____ Cell Phone:( ) _____ E-mail address: _____

Employer: _____ Work Phone: ( ) _____ Spouse Name: _____

Spouse Employer:_____ Work Phone: ( ) _____ Spouse DOB: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Physician: _____ Primary Physician: _____

Pharmacy & Location: _____ Phone: ( ) _____

I give permission for The Woman's Place to contact the patient's pharmacy for a list of medications. ❑ Yes ❑ No

Race: ❑ Hispanic ❑ Asian ❑ Caucasian ❑ Black/African American ❑ American Indian or Alaska Native ❑ Other: _____

Ethnicity (Nationality-cultural background): ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Other

Primary Language: _____

-Complete if Student or Minor-

Father Information

Name: _____

Address: _____

City, St., Zip: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Employer: _____

SS#: _____ DOB: _____

Mother Information

Name: _____

Address: _____

City, St., Zip: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Employer: _____

SS#: _____ DOB: _____

-Person Responsible for Payment of Account-

Name: _____ Relationship: _____

Address: _____ Home Phone: ( )_____

City, St., Zip: _____ Other Phone: ( )_____

-Insurance Information-

Please Present Card(s) for Copying

Primary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Card Holder's Name: _____DOB: _____ SS#: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Card Holder's Name: _____ DOB: _____ SS#: _____

I hereby give my consent to The Woman's Place and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If The Woman's Place chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative: _____ Date: _____

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-Acknowledgement of Receipt of Privacy Notice-

I acknowledge I have received a copy of The Woman's Place's Notice of Privacy Practices effective April 2003.

-Authorization for Medical Care-

I hereby authorize The Woman's Place to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-Referral Waiver-

I acknowledge in the course of my treatment, The Woman's Place, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. The Woman's Place will notify me when such a referral occurs. The Woman's Place assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should The Woman's Place make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. The Woman's Place is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below***, I give permission to the person(s) listed to receive LIMITED information about my care***. I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. **Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization.** This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1. ☐ Do **NOT** share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times. ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times. ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicans/providers who participate in my care:

Name: _____ **Name:** _____

_____ _____ _____
Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: _____
Date of Service: _____

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(First) (M) (Last)

Office Use Only:

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

PATIENT QUESTIONNAIRE

Reason for today's visit (please list any symptoms that you would like to discuss with your doctor): _____

_____

_____

Are you trying for pregnancy: ❑Yes ❑No ❑Possible ❑Not Applicable

Are you currently pregnant: ❑Yes ❑No ❑Possible ❑Not Applicable

Do you desire STI (sexually transmitted infection) screening: ❑Yes ❑No

Health Protocol

Please indicate if you have had any of these:

					Date of Last						Date of Last
Cholesterol Screening	❑	Yes	❑	No		Tetanus Vaccine	❑	Yes	❑	No	
Stool cards for hidden blood	❑	Yes	❑	No		Influenza Vaccine	❑	Yes	❑	No	
GYN Exam/Pap Smear	❑	Yes	❑	No		HPV Vaccine	❑	Yes	❑	No	
Sigmoidoscopy/Colonoscopy	❑	Yes	❑	No		DEXA Scan	❑	Yes	❑	No	
Pneumococcal Vaccine	❑	Yes	❑	No		Mammogram	❑	Yes	❑	No	
Hepatitis B Vaccine	❑	Yes	❑	No							

History of STI

- ❑ Gonorrhea
- ❑ Chlamydia
- ❑ Herpes
- ❑ HPV (abnormal pap)
- ❑ Syphilis
- ❑ Trichomonas
- ❑ Genital warts
- ❑ HIV

Please list all medications which you are currently taking: (include vitamins, supplements, herbs, etc.)

Medication	Dose	Reason

Do you have any medication allergies? ❑ Yes ❑ No If yes, please list below:

Medication	Reaction
	❑ Rash ❑ Swelling ❑ Wheezing ❑ Shock ❑ Stomach upset ❑ Other *Severity:* ❑ Mild ❑ Moderate ❑ Severe
	❑ Rash ❑ Swelling ❑ Wheezing ❑ Shock ❑ Stomach upset ❑ Other *Severity:* ❑ Mild ❑ Moderate ❑ Severe
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Gynecological Medical History

Last Pap: _____ First day of last menstrual cycle: _____ Age of first menstrual cycle: _____
Birth control method:_____ Age at onset of menopause (if applicable): _____

Are your periods regular? ❑Yes ❑No How many days do you flow? _____ Days between flow: _____
Do you have pain with periods? ❑Yes ❑No Does pain start before or during? ❑Before ❑During
Is the pain: ❑Mild ❑Moderate ❑Severe
Do you have heavy periods? ❑Yes ❑No How many pads or tampons/day? _____
Is the bleeding: ❑Mild ❑Moderate ❑Severe
Do you have pain in between periods? ❑Yes ❑No Is the pain: ❑Mild ❑Moderate ❑Severe
Do you have bleeding between periods? ❑No ❑With ovulation ❑Just before period ❑After period ❑Irregular
Do you have bleeding after intercourse *(sex)*? ❑Always ❑Sometimes ❑Never

If you are perimenopausal or menopausal, are you experiencing?
❑Hot Flashes ❑Night Sweats ❑Sleep disturbances ❑Mood Swings ❑Vaginal Dryness

Do you have vaginal discharge? ❑Yes ❑No
Type: ❑White ❑Yellow ❑Brown ❑Green ❑Clear ❑Thick ❑Thin ❑Painful ❑Itching ❑Burning

Do you leak urine? ❑Yes ❑No
If yes: ❑With cough or laugh ❑Spontaneously

Have you had an abnormal pap smear? ❑Yes ❑No Date: _____
Have you ever had cervical treatment?: ❑Yes ❑No Date: _____

Do you have problems with your breasts?
A mass or lump? ❑Right ❑Left ❑Both
Pain? ❑Right ❑Right ❑Left ❑Both
Discharge from the nipple? ❑Right ❑Left ❑Both

How many times have you been pregnant (including miscarriage / termination / ectopic)? _____
How many living children do you have currently? _____

Obstetric History *(list pregnancies, miscarries and abortions in order)*

	Year	Type of Delivery	M or F	Weight	Complications
1					
2					
3					
4					
5					
6					
7					
8					

*List additional information on the back
Date of Service: _____

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(First) (M) (Last)

Past Medical History ❑None

Please indicate if you have experienced any of the following conditions. Please include the date of the experience.

- ❑ Abnormal pap - Year:_____
- ❑ Anemia
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Bartholin's gland cyst
- ❑ History of blood transfusion
- ❑ Breast cancer
- ❑ Breast mass
- ❑ Bruising or bleeding disorder
- ❑ Cerebrovasuclar accident (stroke)
- ❑ Cervical cancer
- ❑ Clotting disorder
- ❑ Congenital heart disease
- ❑ Cystocele
- ❑ Depression
- ❑ DES Exposure
- ❑ Diabetes - Type: _____
- ❑ Drug/Alcohol use
- ❑ Endometriosis
- ❑ Family history of genetic disorder
- ❑ Prior fetal death
- ❑ Fibroid uterus
- ❑ Gallbladder disease
- ❑ Genital herpes, exposure
- ❑ History of genital herpes
- ❑ Heart murmur
- ❑ Hemoglobinopathy
- ❑ Hepatitis/Liver disease
- ❑ Hypercoagulable disorder
- ❑ Hyperlipidemia (high cholesterol)
- ❑ Hypertension (high blood pressure)
- ❑ Incompetent cervix
- ❑ Infertility
- ❑ Prior stillbirth
- ❑ Superficial thrombophlebitis
- ❑ Obesity
- ❑ Ovarian cancer
- ❑ Ovarian cyst
- ❑ Pelvic Inflammatory Disease
- ❑ Polycystic ovary syndrome
- ❑ Prolapsed uterus
- ❑ Premature rupture of membranes
- ❑ Preterm delivery, prior
- ❑ Psychiatric disease
- ❑ Pulmonary embolism (blood clot - lung)
- ❑ Recurrent miscarriages
- ❑ Seizure disorder
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Uterine cancer
- ❑ UTI, h/o recurrent
- ❑ Vaginal infections, recurrent
- ❑ Deep venous blood clots - leg(s)
- ❑ Myocardial Infarction (heart attack
- ❑ Sleep apnea
- ❑ Other Medical Procedures: _____

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Please check all that apply:

Female Surgical History ❑ N/A **Date**

- ❑ Total abdominal hysterectomy with or without removal of ovaries _____
- ❑ Bilateral Tubal Ligation or other sterilization _____
- ❑ D and C (Dilation and Curettage) _____
- ❑ Breast Biopsy _____
- ❑ LEEP/Cone Biopsy _____
- ❑ Endometrial Ablation _____
- ❑ Other: _____ _____
- ❑ Vaginal hysterectomy with or without removal of ovaries _____
- ❑ Hysteroscopy +/- D&C _____
- ❑ Breast Reduction _____
- ❑ Augmentation Mammoplasty _____
- ❑ Mastectomy (specify right or left) _____
- ❑ Cesarean (#_____) _____

General Surgical History ❑ N/A **Date**

- ❑ Angioplasty _____
- ❑ Angioplasty with stent _____
- ❑ Appendectomy _____
- ❑ Back surgery _____
- ❑ Coronary Artery Bypass Graft _____
- ❑ Carpal tunnel release _____
- ❑ Removal of gallbladder _____
- ❑ Removal of part of your colon _____
- ❑ Drainage of your colon to abdomen bag _____
- ❑ Eye Surgery _____
- ❑ Gastric bypass _____
- ❑ Hernia repair _____
- ❑ Hip surgery or replacement _____
- ❑ Knee surgery or replacement _____
- ❑ Liver biopsy _____
- ❑ Pacemaker _____
- ❑ Small or Large bowel resection _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy +/- adenoids _____
- ❑ Other:_____ _____

Family History

❑Adopted (history unknown)

❑ NONE OF THESE APPLY TO MY FAMILY	Mother	Father	Sister	Brother	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)	Child	Other
Asthma										
Alzheimer's/ Dementia										
Blood clots										
Cancer										Specify:
Diabetes										
Elevated Cholesterol										
Heart disease										Specify:
Hypertension										
Kidney disease										
Liver disease										
Lupus										
Osteoarthritis										
Osteoporosis										
Rheumatoid arthritis										
Seizures										
Stroke										

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Social History

Highest grade completed in school? _____ **Are you still in school?** ❑Yes ❑No

Occupation: _____ **Marital Status**: ❑Single ❑Married ❑Widowed ❑Divorced

Who lives at home with you (specify number of daughters/sons)? _____

Tobacco Use: ❑Current ❑Former ❑Never **Type:** ❑Chewing ❑Cigar ❑Cigarette ❑Pipe
Amount per day: _____ **Number of years used:** _____ **Year quit:** _____

Alcohol Use: ❑Current ❑Never ❑Former **Type:** ❑Beer ❑Wine ❑Hard liquor
How often do you drink? ❑Daily ❑Weekly ❑Monthly ❑Rarely **Amount:** _____

Illicit Drug Use: ❑Current ❑Never ❑Former **Age started:** _____ **Year quit:** _____
Type: _____ **Frequency:** _____ **Last use:**_____

History of child of abuse? ❑Yes ❑No **Offender(s):** _____ ❑Physical ❑Sexual ❑Verbal

History of domestic violence? ❑Yes ❑No **Perpetrator(s):** _____

Are you sexually active? ❑Yes ❑No **Orientation:** ❑Heterosexual ❑Homosexual ❑Bisexual

How many partners have you had sex with? _____ **How old were you when you first had sex?** _____

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(First) (M) (Last)

Review of Systems

❑ **NONE OF THESE APPLY TO ME**

Constitutional
- ❑ Chills
- ❑ Fever

HEENT
- ❑ Blurred vision
- ❑ Double vision
- ❑ Eye pain
- ❑ Headache
- ❑ Ear infection
- ❑ Sore throat

Respiratory
- ❑ Asthma
- ❑ Chronic cough
- ❑ Difficulty breathing
- ❑ Wheezing

Cardiovascular
- ❑ Chest pain
- ❑ Irregular heartbeat Palpitations
- ❑ Edema

Gastrointestinal
- ❑ Constipation
- ❑ Decreased appetite
- ❑ Diarrhea
- ❑ Nausea/vomiting

Genitourinary
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Sexual dysfunction
- ❑ Vaginal discharge
- ❑ Vaginal itching

Metabolic
- ❑ Cold intolerant
- ❑ Heat intolerant
- ❑ Increased Thirst
- ❑ Weight Gain
- ❑ Weight Loss

Neuro/Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Incontinence
- ❑ Tremors
- ❑ Vision changes

Dermatologic
- ❑ Changing of color mole(s)
- ❑ Itching skin
- ❑ Rash
- ❑ Chronic hives

Musculoskeletal
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle pain

Hematologic
- ❑ Easy bleeding
- ❑ Easy bruising

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