Ann M. Hentzen Page, MD, FACOG

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: ________________________ (First) _____ (MI) ___________________________ (Last) SS#:______________________________

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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Date of Birth: _______________ Patient Chart: ____________

Patient Name: __________________ (First) ________________ (MI) ___________________ (Last)

-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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Patient Name: __________________ ________________ ___________________
First) (MI) (Last)

Office Use Only: Height: ______________ Weight: ______________ Blood Pressure: ______________ Pulse: ______________

NEW OB PATIENT QUESTIONNAIRE

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

____

____

____

____

First day of last menstrual cycle: _________________ ❑Sure ❑Unsure ❑Unknown

Are your periods regular: ❑Yes ❑No

How many days do you flow? ____________ Days between flow: _____________

Were you on birth control at conception: ❑Yes ❑No Birth control method: __________________________

Have you had a positive pregnancy test: ❑Yes ❑No

If so, where was the test taken? ❑Home ❑Doctor's Office Date of test: ___________________

Weight prior to pregnancy: ________________

How many times have you been pregnant (including miscarriage / termination / ectopic)? ___________________

How many living children do you have currently: __________________

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

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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Patient Name: __________________ ________________ ___________________
First) (MI) (Last)

Past Medical History ❑None

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

- ❑ Diabetes - Type: ________________
- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Autoimmune Disease
- ❑ Kidney disease/ UTI, recurrent
- ❑ Epilepsy
- ❑ Psychiatric Problems
- ❑ Depression
- ❑ Hepatitis/Liver disease
- ❑ Varicose Veins
- ❑ Thyroid problems
- ❑ Recent Trauma or Injury
- ❑ History of Blood Transfusion
- ❑ RH Sensitized
- ❑ Asthma/ Tuberculosis (TB)
- ❑ Problems with Anesthesia Breast Problems
- ❑ Breast Problems
- ❑ History of Abnormal Pap - Treatment:_____________
- ❑ Uterine Anomaly/ DES Exposure
- ❑ Infertility
- ❑ Infertility Treatments

Please check all that apply:

Infection History ❑ N/A	**Date**		**Date**
❑ Exposed to TB	____________	❑ History of Gonorrhea	____________
❑ Partner with herpes	____________	❑ History of Chlamydia	____________
❑ Personal history of herpes	____________	❑ History of HPV	____________
❑ Rash or viral illness since last period	____________	❑ History of HIV	____________
❑ History of Hepatitis B or C	____________	❑ History of Syphilis	____________

Please check all that apply:

Female Surgical History

❑ N/A	**Date**		**Date**
❑ D and C (Dilation and Curettage)	____________	❑ Hysteroscopy +/- D&C	____________
❑ Breast Biopsy	____________	❑ Breast Biopsy	____________
❑ LEEP/Cervical Treatment	____________	❑ Breast Reduction	____________
❑ Endometrial Ablation	____________	❑ Breast Augmentation	____________
❑ Tubal Ligation	____________	❑ Mastectomy (specify right or left)	____________
❑ **Other:** ____________________	____________	❑ Cesarean (#__________)	____________

Date of Service: _________________

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Patient Name: __________________ (First)   ________________ (MI)   ___________________ (Last)

Please list any other operations and/or hospitalizations: ____

____

____

____

____

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
	❑ Rash ❑ Swelling ❑ Wheezing ❑ Shock ❑ Stomach upset ❑ Other *Severity:* ❑ Mild ❑ Moderate ❑ Severe

Please list any Medications/Drugs/Alcohol used since last period: ______________________________________

____

____

____

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Patient Name: __________________ (First) _________________ (MI) ____________________ (Last)

FAMILY Genetic/Teratolgy Screening

❑Adopted (history unknown)

❑ **NONE OF THESE APPLY TO MY FAMILY**	Mother	Father	Sister	Brother	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)	Child	Other
Thalassemia (Italian/Greek/Mediteranean/ Asian Descent)										
Spinal Cord Defect										
Congenital Heart Defect										
Down Syndrome										
Tay-Sachs										
Canavan Disease										
Familial dysautonomia										
Sickle Cell Disease										
Hemophilia										
Muscular Dystrophy										
Cystic Fibrosis										
Huntington's Chorea										
Mental Retardation										
Autism										
Other Genetic Problems										**Specify:**

PERSONAL Genetic/Teratolgy Screening

- ❑ History of Diabetes
- ❑ Phenylketonuria (PKU)
- ❑ Thyroid Disease
- ❑ **Other Hormonal Problems**
- ❑ Recurrent Miscarriages
- ❑ History of Stillbirth
- ❑ Previous Baby with Birth Defect

❑Patient OR ❑Partner

Date of Service: _________________

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Patient Chart: ____________

Patient Name: __________________ (First) ________________ (MI) ___________________ (Last)

Social History

Primary Language: ❑English ❑Spanish ❑Other: ____

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Father's Name (Baby's Father): ____

Father's Race: ❑Hispanic ❑Asian ❑Caucasian ❑Black/African American ❑American Indian or Alaska Native

❑ Other: ____

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

Occupation: ___________________________________

How often do you exercise? ❑Never ❑Occasionally ❑Frequently ❑Daily Type: ______________________________

How often do you use seat belts? ❑Never ❑Occasionally ❑Always

Do any cats live in your home? ❑Yes ❑No

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):** ____

Date of Service: ________________

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Patient Name: __________________ (First) ________________ (MI) ___________________ (Last)

Review of Systems

❑ NONE OF THESE APPLY TO ME

Constitutional

- ❑ Change in Appetite
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Irritability
- ❑ Night Sweats

HEENT

- ❑ Headache
- ❑ Eye Pain
- ❑ Loss of Vision
- ❑ Ear Infections
- ❑ Nasal Congestion
- ❑ Sore Throat
- ❑ Snoring
- ❑ Tooth Pain

Respiratory

- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing

Cardiovascular

- ❑ Chest Pain
- ❑ Fainting
- ❑ Swelling in Legs
- ❑ Irregular Heartbeat/Palpitations

Gastrointestinal

- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Vomiting

Genitourinary

- ❑ Pain with Urination
- ❑ Urinary Frequency
- ❑ Blood in Urine
- ❑ Vaginal Itching
- ❑ Vaginal Discharge

Metabolic/Endocrine

- ❑ Weight Gain
- ❑ Weight Loss

Neuro/Psychiatric

- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

Dermatologic

- ❑ Itching Skin
- ❑ Skin Rashes
- ❑ Hives

Musculoskeletal

- ❑ Back Pain
- ❑ Joint Problems
- ❑ Muscle Pain
- ❑ Weakness

Hematologic

- ❑ Easy Bleeding
- ❑ Easy Bruising
- ❑ History of Blood Clots

Immunologic

- ❑ Asthma

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							

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