Camelback Women's Health

PATIENT INFORMATION

Patient Name: Last, First, MI			Maiden Name:	Date of Birth:
Address:	City:	State:	Zip:	Social Security #:
Home Phone: ( )	Work Phone & Ext. ( )	Cell Phone: ( )		
E-mail Address:		Marital Status: S M D W		
Occupation:	Employer Name:			
Contact Preference: ____Home ____Work ____Cell ____E-mail	**Race (optional):** ___African American ___Asian ___ Asian Indian ___Native American ___ Pacific Islander ___ White			**Ethnicity (optional):** ___ Hispanic/Latino ___ Not Hispanic/Latino

Spouse/ Significant Other or Parent Name: Last, First, MI		Date of Birth:
Work Phone & Ext. ( )	Cell Phone: ( )	
Occupation:	Employer Name:	

Emergency Contact: (Other than spouse/significant other)		Relationship:
Home Phone: ( )	Work Phone & Ext. ( )	Cell Phone: ( )

Primary Care Physician:	Phone Number:
Preferred Pharmacy:	Phone Number & Location:

How were you referred to Camelback Women's Health? _____ Social Media _____ Advertisement _____ Internet Search _____ Friend/Family Member _____ Primary Care Physician _____ Insurance Booklet _____ Please Explain:

My **PRIMARY** insurance policy is through: ****THE EMPLOYEE IS CONSIDERED THE POLICY HOLDER***

____ My Employer ____ Spouse's Employer _____ Mother's Employer _____ Father's Employer ____ State/Federal

Insurance Company Name:	Policy Holder Name:		Policy Holder DOB:
ID #:	Group #:	Social Security # of policy holder:	
Claims Address:	City:	State:	Zip:
Insurance Phone: ( )	Relationship to Policy Holder:		

My **SECONDARY** insurance policy is through: ****THE EMPLOYEE IS CONSIDERED THE POLICY HOLDER***

____ My Employer ____ Spouse's Employer ____ Mother's Employer ____ Father's Employer ____ State/Federal

Insurance Company Name:	Policy Holder Name:		Policy Holder DOB:
ID #:	Group #:	Social Security # of policy holder:	
Claims Address:	City:	State:	Zip:
Insurance Phone: ( )	Relationship to Policy Holder:		

I certify the above information is correct and understand I am required to provide a photo ID for the protection of my personal information:

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____

Camelback Women's Health

Authorization to Share Protected Information

Camelback Women's Health **DOES NOT** release private health information to anyone without specific written authorization to do so.

Protection of confidential information also applies to spouses, partners, and parents (including parents of minors in certain circumstances) in accordance with state and federal laws.

Please mark one:

_____ **I do not wish to have my personal and confidential information shared with anyone other than myself.**

_____ I am giving Camelback Women's Health permission to share my personal, protected and confidential information with the individuals I have listed below. I understand this authorizes complete access to the following protected information including, but not limited to: laboratory results, radiology results, physician notes, assessments, findings, and opinions, as well as, financial information relating to account status, collection status, and payment history:

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

Name: _____ Relationship: _____ SS# or DOB _____

This authorization will remain in effect ***indefinitely*** unless a specific date is written here: _____

I understand this authorization may be revoked or revised at any time by me in writing. I understand Camelback Women's Health cannot be held responsible for information released under this agreement prior to the receipt of a written revocation and I will not hold Camelback Women's Health responsible for such disclosures.

I understand I will need to provide separate written authorization to receive copies of my protected health information. Photocopying fees will apply unless records are sent directly to another physician.

I have read this agreement and understand my personal protected health information **will not** be shared unless I have specifically indicated the approved individuals above.

_____

Patient Name

_____ _____

Patient Signature Date

Camelback Women's Health

Patient Health History Questionnaire

Patient Name:	Date of Birth:

What is the reason you're being seen today?

MEDICATION ALLERGIES □ **NO KNOWN DRUG ALLERGIES**

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

CURRENT MEDICATIONS □ **NONE**

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

VACCINES □ **NONE**

☐ HPV/Gardasil Date: _____

☐ Tdap Date: _____

☐ Influenza Date: _____

ACTIVE/CURRENT HEALTH PROBLEMS □ **NONE**

1.) _____ Onset Date: _____

2.) _____ Onset Date: _____

3.) _____ Onset Date: _____

4.) _____ Onset Date: _____

GYNECOLOGICAL HISTORY

Date of last Pap Smear	
Date of last HPV testing	
History of abnormal pap	□ Yes
History of HPV	□ Yes
Date of last mammogram	
Date of last colonoscopy	
Date of last bone density	
Date of last cholesterol test	
Date of last diabetes screen	
History of cervical dysplasia	□ Yes
History of vulvar dysplasia	□ Yes
Sexually active	□ Yes
Age at first intercourse	
Total lifetime partners	
History of STD	□ Yes
Current birth control method	
Age at first period	
Age at menopause	
Do you take HRT	□ Yes
History of endometriosis	□ Yes
History of fibroids	□ Yes
History of infertility	□ Yes
History of recurrent ovarian cysts	□ Yes
History of PCOS	□ Yes
History of painful periods	□ Yes
How long do your periods last	
Do you have regular monthly periods	□ Yes
Are your periods heavy	□ Yes

OBSTETRIC HISTORY

Date of Delivery	Outcome?	# Babies	Birth Weight	Wks at Birth	Sex	Delivery Type	Problems/Complications
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	

FAMILY HISTORY □ **NONE**

Relationship	Health Problem	Onset Age	Age of Death
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ ☐ Other:		
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ ☐ Other:		
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ Other:		
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ ☐ Other:		

SOCIAL HISTORY

Relationship Status	□ Single □ In a relationship □ Married □ Divorced □ Widowed
Spouse/Partner's Name	
Assigned Gender at Birth	Patient: □ Female □ Male Partner: □ Female □ Male
Are you/have you been a victim of abuse?	□ Sexual □ Physical □ Emotional
Is the abuse on-going?	□ Yes, Please explain:
Tobacco use	□ Never □ Former □ Current # Years: Frequency:
Other forms of nicotine/tobacco	□ Yes □ E-Cigarettes □ Vape □ Patch □ Other
Have you had tobacco cessation counseling	□ Yes
Alcohol use	□ None □ Occasional □ Moderate □ Heavy How many in past week?
How many days in the past year have you consumed 4 or more drinks	
Do you use recreational or illicit drugs	□ Yes How many times in the past year?
Caffeine consumption	□ None □ Occasional □ Moderate □ Heavy
What type of diet are you following	□ Regular □ Vegetarian □ Vegan □ Gluten-free □ Specific □ Carbohydrate □ Cardiac □ Diabetic
Exercise level	□ None □ Occasional □ Moderate □ Heavy
Highest level of education	□ Prefer not to answer □ High school graduate □ Some college □ Trade School □ Associates □ Bachelors □ Masters □ PhD
Are you currently in school	□ Yes
Are you currently employed	□ Yes
What is your occupation	
Do you have an advanced directive	□ Yes
Is a blood transfusion acceptable in an emergency	□ Yes □ No

PAST SURGERIES □ **NONE**

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

PAST MEDICAL HISTORY **(If no, leave blank)**

		Yes	Comments
Breast			
	Fibrocystic Breasts		
	Other		
Cancer			
	Breast		
	Cervical		
	Colon		
	Endometrial/Uterine		
	Lung		
	Ovarian		
	Skin		
	Vaginal		
	Vulvar		
	Other		
Cardiology			
	Arrythmia		
	Atrial Fib/flutter		
	Coronary Artery Disease		
	Elevated cholesterol		
	Heart attack		
	Heart disease		
	High blood pressure		
	Murmur/Mitral Valve Prolapse		
	Other		
Dermatology			
	Acne		
	Eczema		
	Latex allergy		
	Psoriasis		
	Other		
Endocrine			
	Diabetes		
	Glucose Intolerance/Insulin Resistance		
	Hyperthyroidism		
	Hypothyroidism		
	Osteopenia		
	Osteoporosis		
	Prolactinoma		
	Vitamin Deficiency		
	Other		

		Yes	Comments
ENT			
	Seasonal Allergies		
	Other		
Gastrointestinal			
	Celiac Disease		
	Crohn's/Ulcerative Colitis		
	Gallbladder Disease		
	Hemorrhoids		
	Irritable Bowel Syndrome		
	Reflux/Ulcers		
	Other		
Genetics			
	Cancer Gene		
	Birth Defects or Inherited Disease		
	Cystic Fibrosis Screening Positive		
	Fragile X Screening Positive		
	SMA Screening Positive		
	Other		
Hematology			
	Anemia		
	Bleeding Disorder/Thrombophilia		
	Blood Clotting Disorder/Factor V Leiden		
	Blood Transfusion		
	DVT/Pulmonary Embolism		
	Other		
Infectious Disease			
	Chicken Pox		
	Hepatitis		
	HIV/AIDS		
	MRSA		
	Positive PPD/TB		
	Shingles		
	Other		
Nephrology			
	Kidney Infections		
	Kidney Stones		
	Renal/Kidney Disease		
	Other		
Neurology			
	Aneurism		
	Autism		
	Dementia		
	Headaches/Migraines		
	Multiple Sclerosis		
	Seizures/Epilepsy		
	Stroke/TIA		
	Other		
Ob/Gyn (Cont.)			
	Gestational Diabetes		
	Herpes		
	Pelvic Pain		
	Pelvic Prolapse		
	Polycystic Ovary Syndrome		
	Preeclampsia		
	Premature Ovarian Failure		
	STD		
	Other		

		Yes	Comments
Orthopedic			
	Chronic Back Pain		
	Fractures		
	Other		
Psychiatric			
	ADD/ADHD		
	Anxiety Disorder		
	Bipolar Disease		
	Depression		
	Eating Disorder		
	Mental Illness/Disorder		
	PMS/PMDD		
	PTSD		
	Other		
Pulmonary			
	Asthma		
	Other		
Rheumatology			
	Arthritis		
	Autoimmune Disease		
	Chronic fatigue syndrome		
	Connective Tissue Disorder		
	Fibromyalgia/Chronic Pain		
	Other		
Urology			
	Interstitial cystitis		
	Bladder Problems		
	Hematuria (blood in urine)		
	Urinary Incontinence		
	Urinary Tract Infections		
	Other		

I certify information above is true and correct to the best of my knowledge:

_____

Patient Name

_____ _____

Patient Signature Date