Azalea Women's Healthcare Date _____/_____/_____

HISTORY FORM

Legal Name _____ **Date of Birth** _____/_____/_____

Previous last names _____

Race: ___White ___Black/African American ___American Indian ___Asian Other_____

Ethnic background: ___Hispanic or Latino ___Not Hispanic or Latino ___Declined Other_____

Any cultural or religious beliefs that may affect your medical care? _____

Emergency contact(s) name _____

Address & phone number of emergency contact _____

_____

Your preferred Pharmacy Name, Address and Phone Number: _____

_____

Reason for office visit today:_____

Date of Last Pap Smear _____/_____/_____ Date of Abnormal Pap Smear _____/_____/_____

Please provide approximate dates of any previous radiological examinations from the list below:

Mammogram ____/____/____ Bone density ____/____/____ Colonoscopy ____/____/____

Have you had any of the following immunizations/vaccines:

____MMR (Measles/Mumps/Rubella) ____ Gardasil ____Tetanus booster ____Meningitis

Have you had the Chicken Pox or been vaccinated for it? _____

Please list any medical conditions you may have (asthma, diabetes, hypertension, STD's, etc.):

_____

_____

Please list any surgical procedures/operations you have had and the dates they were performed:

Date	**Operation**
_____	_____
_____	_____
_____	_____

Please list all of your medications, the doses, and how frequently you take them:

Medication	Dose/Strength	Frequency

Have you had allergic reactions to any medications? If so, please list:

Name of medication	Reaction

REPRODUCTIVE HISTORY:

How old were you when you had your first period? _____ Date of 1st day of last period _____/_____/_____

How frequent are your periods? (How many days from beginning of one to the next?) _____

Duration (usual number of days of flow) _____ Flow: (circle one) Heavy Moderate Light

Do you have bleeding/cramping/spotting between periods? Yes or No

Do you feel as though your periods impact the quality of your life? Yes or No

What do you use to keep from getting pregnant? _____

Are you planning another child? ____ Within this year ____ Within 5 years ____ Within 10 years ___ No

If you are menopausal, at what age did you have your last period? _____

Do you ever leak urine when you cough, laugh or sneeze? Yes or No

Have you ever had (please circle any that apply): Syphilis; Sores; Gonorrhea (G.C., "Clap", or "Drip"); Chlamydia; Herpes (blisters); Trichomonas; HPV ("warts"); Hepatitis; pelvic or tubal infection or inflammation (PID); or HIV

PREVIOUS PREGNANCIES: (first to last)

Date:	Delivery: Vaginal, C-Section, Miscarriage, Abortion	Sex of Baby:	Baby's Birth Weight:	Mother's Weight Gain:	Hours of Labor:	Complications: For Mother	Complications: For Baby

FAMILY HISTORY

List any family members (blood relatives only) with the following medical problems (list relationships, ie mother (M), father (F), sister (S), brother (B), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF), etc.)

CARDIAC

Stroke _____
Heart disease _____
High blood pressure _____
High cholesterol _____
Blood clots _____
Pulmonary embolism _____

DIGESTIVE/GASTROINTESTINAL

Celiac disease _____
Colon polyps _____
Familial polyposis _____
Ulcerative colitis _____
Crohn's disease _____
Hepatitis _____

ENDOCRINE

Diabetes (sugar) _____
Thyroid disorder _____
Graves disease _____

HEMATOLOGIC

Factor VIII disorder _____
Von Willebrand's disease _____
Sickle cell disease/trait _____
Hereditary spherocytosis _____

MUSCULOSKELETAL

Arthritis _____
Osteoporosis _____
Osteopenia _____

NEOPLASMS/MALIGNANCY

Ovarian cancer _____
Uterine cancer _____
Breast cancer _____
Colon cancer _____
Other malignancy _____
Cervical cancer _____

NEUROLOGIC

Alzheimer's disease _____
Parkinson's disease _____
Seizure disorder _____

PSYCHIATRIC

Bipolar disorder _____
Depression _____
Schizophrenia _____
Alcoholism _____

RESPIRATORY

Tuberculosis _____
COPD _____
Emphysema _____
Lung Cancer _____

OTHER

Cystic fibrosis _____
Scleroderma _____
Lupus _____
_____

SOCIAL HISTORY:

Do you ever drink alcohol? Yes/No How often on average? _____ How many drinks per time? _____

Have you ever smoked? Yes/No How many years? ____ How many per day? ____ When did you quit? _____

Do you use any other non-prescription drugs? Yes/No If yes, what type? _____

How old were you when you had sex for the first time? _____

How many sexual partners have you had in your lifetime? (circle one) 0 – 1 2 – 5 More than 5

Last grade completed? _____ Did you attend college? Yes/No

How did you find out about or choose us? (circle) Physician Friend Azalea Website WCTV HealthLinks

Billboard Yellow Pages TV Commercial Newspaper Other _____

What is your occupation? _____

What is your marital status? (circle) Single Dating Engaged Married Divorced Widowed

OFFICE ONLY: Height _____' _____" Weight _____ BP _____/_____ HGB _____ U/A ___ __ Temp _____ G _____ P _____

NOTES:

Azalea Women's Healthcare

Patient Information

Name: _____ Home Phone:_____

Address:_____ Work Phone: _____

City, State, Zip: _____ Alt. Phone: _____

Date of Birth: _____/_____/_____ Age:_____ Marital Status: ( )Single ( ) Married ( ) Divorced

Social Security # _____-_____-_____ Race: ( ) Black/African American ( ) White
( ) Other _____ ( ) Declined

Driver's License **#**_____ Ethnicity: ( ) Hispanic ( ) Non-Hispanic

Patient Employment

( )Employed ( )Retired ( ) Unemployed

Employer:_____

Emergency Contact

Name: _____

Phone #: _____

Responsible Party (If other than patient)

Name:_____ Employer:_____

Address: _____ Work Phone: _____

City, State: _____ Alternate Phone: _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Primary Insurance **Check One**. ( )BCBS ( )CHP ( )Vista ( )MCR ( )MCD ( )Other _____

Policy Holder : _____ Relationship to Patient:_____

Insurance Co:_____ Policy ID # _____Group #_____

Policy Holder Date of Birth: _____/_____/_____ Policy Holder SS # _____-_____-_____

Medicare Secondary Insurance ( ) Same as Patient ( ) Same as Guarantor

Policy Holder:_____ Relationship to Patient:_____

Insured Phone:_____ Social Security # _____-_____-_____

Insurance Co:_____ Policy ID # _____Group #_____

I, the below signed patient, certify that the above information is correct and understand that if any information is incorrect, I will be financially responsible for all costs incurred from the visit. I understand that Azalea Women's Healthcare will file my insurance as required by contracts, where applicable, and that I am responsible for full payment to Azalea Women's Healthcare for services provided. Furthermore, I authorize Azalea Women's Healthcare to release pertinent medical records for documentation of services in order to process medical insurance claims.

Signature _____ **Date** _____**/**_____**/**_____

AZALEA WOMEN'S HEALTHCARE

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

_____, herein after referred to as **PATIENT**, hereby consents to the use or disclosure of his/her individually identifiable health information (Protected Health Information or PHI) by Azalea Women's Healthcare, herein after referred to as **FACILITY**, in order to carry out treatment, payment, or health care operations. The patient should review the **FACILITY'S** Notice of Privacy Practices for **PHI** for a more complete description of the potential uses and disclosures of such information, and the **PATIENT** has the right to review such Notice prior to signing this consent form.

The **FACILITY** reserves for itself the right to change the terms of its Notice of Privacy Practices for **PHI** at any time. If **FACILITY** does change the terms of its Notice of Privacy Practices, **PATIENT** may obtain a copy of the revised Notice by contacting Adrienne George, MD, **PRIVACY OFFICER** at (850)877-5767.

PATIENT retains the right to request that the **FACILITY** further restrict how his/her **PHI** is used or disclosed to carry out treatment, payment, or health care operations. The **FACILITY** is not required to agree to such requested restrictions; however, if the **FACILITY** does agree to **PATIENT'S** requested restriction(s), such restrictions are then binding on the **FACILITY**.

At all times, **PATIENT** retains the right to revoke this Consent. Such revocation must be submitted to the **FACILITY** in writing. The revocation shall be effective except to the extent that the **FACILITY** has already taken action in reliance to the Consent.

The **FACILITY** may refuse to treat **PATIENT** if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the **FACILITY** is required by law to treat individuals). If **PATIENT** (or authorized representative) signs this Consent form and then revokes Consent, the **FACILITY** has the right to refuse to provide further treatment to **PATIENT** as of the time of revocation (except to the extent that the **FACILITY** is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT, TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATE TERMS. I HAVE ALSO RECEIVED A COPY OF THE NOTICE OF PRIVACY POLICIES FOR MY REVIEW AND RECORD.

Date: _____ ***Time*** _____ ***AM/PM***

_____
Signature of Patient

_____
Authorized Representative Signature & Relationship to Patient

_____
Please Print Name

_____
Please Print Name

1219 Hodges Drive, Tallahassee, FL 32308 Office 850-877-5767 Fax 850-877-5055 www.azaleawomenshealthcare.com