BAYSIDE WOMEN'S HEALTH
PATIENT DEMOGRAPHICS

Chart#:_____ Date:_____

Demographic Information

Name: _____ / _____ /_____ /_____
Last First Middle Maiden

Mailing Address: _____ / _____ /_____ /_____
Address City State Zip Code

Home #:_____ Work #:_____ Cell #:_____

Consent to Text? □ Yes □ No Consent to Call? □ Yes □ No Email Address: _____

SSN: _____ Marital Status: _____ Race: _____

Date of Birth: _____ Age: _____ Employer: _____

Spouse Information

Name of Spouse: _____ DOB: _____ SSN: _____

Employer: _____ Work #: _____ Cell #: _____

Insurance Information (Please notify front desk of additional insurance plans.)

Primary Ins Co.: _____ Contract # _____ Group # _____

Subscriber's Name: _____ Subscriber's DOB: _____ Subscriber's SS# _____

Secondary Ins Co.: _____ Contract # _____ Group # _____

Subscriber's Name: _____ Subscriber's DOB: _____ Subscriber's SS# _____

Referral Information

Were you referred by another physician? □ Yes □ No If yes, please list physician's name:_____

Primary Care Physician: _____ Phone number: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Pharmacy Information

Name: _____ Phone #: _____

Address: _____ / _____ /_____ /_____
Address City State Zip Code

By signing below, I certify that the above information is correct. I will contact Bayside Women's Health immediately with any changes.

_____ _____
Patient Name (printed) Date

_____
Signature of Patient

BAYSIDE WOMEN'S HEALTH
ANNUAL MEDICAL INTAKE FORM

Patient Name: _____ **Chart #:** _____ **Date:** _____

To help your doctor during today's health exam, please complete items 1 through 16.

1. Age: _____ Marital Status: S M D W SEP.

When was the ***FIRST DAY*** of your last period? _____

What method of birth control do you use? _____

2. Number of times you have been pregnant: _____

Number of living children: _____

Are you planning a pregnancy in the next 6-12 months? YES NO

3. When was your last Pap Test? _____

Have you ever had an Abnormal Pap*?* YES NO

***If yes, When?* _____

Did you have any of the following?

Colpo/Biopsies	YES	NO
LEEP/CRYO	YES	NO
Surgery	YES	NO

4. Do you have any of the following:

A. Problems with present method of birth control	YES	NO
B. Bleeding between periods	YES	NO
C. Pain with sex	YES	NO
D. Any problem with interest in or enjoying sex	YES	NO
E. A new or enlarging lump in breast	YES	NO
F. Change in size/firmness of stool	YES	NO
G. Blood clots (leg, lung, etc.)	YES	NO
H. Headaches	YES	NO
I. Pain in joints	YES	NO
J. Pain in chest	YES	NO
K. Pain in abdomen	YES	NO
L. Trouble falling or staying asleep	YES	NO
M. Often feeling down, depressed or hopeless in the past month	YES	NO
N. Often having little/no interest in hobbies/daily activities during the past month	YES	NO
O. Is conflict in your family or relationships, sometimes handled by pushing, hitting, or cruelty?	YES	NO
P. High blood pressure	YES	NO

5. Do you have a parent, grandparent, brother or sister with history of the following:

A. Cancer	YES	NO
B. Heart attacks	YES	NO
C. High Blood Pressure	YES	NO
D. Diabetes	YES	NO

***If yes to any of the above please list them below:*

Relation: _____ Type: _____

Relation: _____ Type: _____

Relation: _____ Type: _____

Relation: _____ Type: _____

6. Have you ***EVER*** used tobacco? YES NO

***If yes, please continue below:*

A. Number of packs/day: _____

B. Number of years smoked: _____

C. Year quit: _____

7. Do you drink alcohol? YES NO

***If yes, please continue below:*

A. How much? (OCC) (MOD) (HEAVILY)

B. Have you ever felt you should decrease your drinking? YES NO

C. Has anyone ever seemed concerned about your drinking? YES NO

D. Have you ever felt guilty about your drinking? YES NO

8. Do you drink caffeine? YES NO

***If yes how much?* _____ *(Cups per day)*

9. Do you currently use illegal drugs? YES NO

10. Which of the following are included in your diet:

Grains/Starches	a lot	some	none
Vegetables	a lot	some	none
Dairy	a lot	some	none
Meats	a lot	some	none
Sweets	a lot	some	none

11. Do you exercise regularly? _____

Activity: _____

Days per week: _____

12. Have you had your cholesterol level checked? YES NO

13. Have you ever had a colonoscopy? YES NO

***If yes, when:* _____

14. Have you ever had a mammogram? YES NO

***If yes, when:* _____

Have you ever had an abnormal mammogram? YES NO

***If yes, when:* _____

15. If you are 65 or older have you ever had a bone density scan? YES NO

***If yes, when:* _____

16. Please describe any problems you are currently having:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

BAYSIDE WOMEN'S HEALTH

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

In the event that our office is unable to reach you, the patient, directly concerning (but not limited to) test results, pathology reports, and other medical information, it is up to your discretion with whom we may share this information with. Please refer to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with any questions.

I authorize Bayside Women's Health to discuss my account and medical conditions - which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information - with the following persons in order to facilitate and coordinate my care, treatment, and payment. (please check appropriately):

□ Myself Only

□ Myself and/or those listed below:

1. Full Name: _____
   Relationship: _____
   Phone #: _____

2. Full Name: _____
   Relationship: _____
   Phone #: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can withdraw this permission by signing a new form at any time. This authorization will remain in effect until I change or revoke it.

_____ _____
Patient Name (printed) Date

_____
Signature of Patient

Authorization Regarding Messages

(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone.

____ Messages may only be left with _____

_____ _____
Patient Name (printed) Date

_____
Signature of Patient