THE CENTER FOR WOMEN, INC.
4139 BOARDMAN-CANFIELD ROAD • CANFIELD, OH 44406
(330) 702-1281

PATIENT INFORMATION

TODAY'S DATE ______________ PREFERRED PHARMACY ________________ LOCATION ________________

PATIENT'S NAME __________________________ DATE OF BIRTH _________________ SS# _________________

RACE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASION ☐ NATIVE HAWAIIAN
☐ AMERICAN INDIAN ☐ HISPANIC ☐ OTHER ______________________________

ETHNICITY __________________________ PREFERRED LANGUAGE _____________________________________

ADDRESS ___________________________________ CITY ______________ STATE ________ ZIP ___________

HOME PHONE _________________ CELL PHONE ____________________ WORK PHONE ____________________

EMAIL ADDRESS ____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME __________________________ DATE OF BIRTH _________________ SS# _________________
(OR RESPONSIBLE PARTY)

FAMILY DOCTOR __________________________ PREVIOUS OB/GYN SEEN ________________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

DO YOU HAVE A LIVING WILL? ________ DO YOU HAVE A DURABLE POWER OF ATTORNEY? ________

EMPLOYER INFORMATION

PATIENT'S EMPLOYER ____
☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED

SPOUSE'S EMPLOYER ____
(OR RESPONSIBLE PARTY)
☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _______________________ RELATIONSHIP TO PATIENT __________________________

PHONE NUMBER ____

I hereby authorize Jennifer Baird, MD; Laura Musser, DO; Gaye Sympson, CNM; Cecelia Gallagan, WHNP; Julie Brennan, WHNP; and/or Stefanie Reed, WHNP to apply for benefits on my behalf for services rendered by them or by their order. I request payment from my insurance company to be made directly to The Center for Women, Inc.
I certify that the information reported with regard to my insurance coverage is correct. If my insurance company does not cover the cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for cellection costs including , but not limited to, collection agency fees, court costs, and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.
I have read, fully understand and agree to the above.

SIGNATURE ____ DATE ____________________
(PATIENT, PARENT, OR GUARDIAN)

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PHONE (330) 702-1281 • FAX (330) 702-1287

PATIENT QUESTIONNAIRE

PATIENT NAME: ______________________ DATE: ______________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

REASON FOR VISIT: ______________________ Age: __________

Last menstrual period: ________ ☐ Not Applicable due to: ☐ Menopause ☐ Mirena IUD ☐ Hysterectomy ☐ Breastfeeding ☐ Ablation ☐ Other

Flow: ☐ Light ☐ Medium ☐ Heavy

Clots: ☐ Yes ☐ No

Severe Cramps: ☐ Yes ☐ No

# of days you bleed: ________

# of days between periods: ________ (i.e. 28,30)

Number of **NEW** sexual partners since last visit: ________ Current Sexual Partner: ☐ Male ☐ Female

Are you currently sexually active? ☐ Yes ☐ No

Type of contraception currently used: ☐ Pills ☐ Condoms ☐ IUD ☐ Other ________ ☐ NuvaRing ☐ Tubal Ligation ☐ Diaphragm ☐ DepoProvera ☐ Vasectomy ☐ Foam

Date of last Colonoscopy: ________ Date of last Mammogram: ________ Date of last Bone Density: ________

Alcohol Use: ☐ Never ☐ Current ☐ Former Amount ________

Recreational Drug Use: ☐ Never ☐ Current ☐ Former Amount ________

Tobacco Use: ☐ Never ☐ Current ☐ Former Amount ________

Domestic Violence: Emotional: ☐ Current ☐ Past Physical: ☐ Current ☐ Past Sexual: ☐ Current ☐ Past

Do you perform breast self exam? ☐ Yes ☐ No

REVIEW OF SYSTEMS Please check if you are **CURRENTLY** experiencing any of these symptoms.

CONSTITUTIONAL	**GASTROINTESTINAL**	**INTEGUMENTARY**
☐ Unexplained Weight Loss	☐ Heartburn	☐ Rash
☐ Unexplained Weight Gain	☐ Nausea	☐ Skin Lesions
☐ Fever	☐ Vomiting	**NEUROLOGIC**
☐ Excessive Thirst	☐ Abdominal Pain	☐ Seizures
☐ Excessive Urination	☐ Bloating	☐ Dizziness
HEENT	☐ Diarrhea	☐ Syncope (Fainting / Passing out)
☐ Headaches	☐ Constipation	**ENDOCRINE**
☐ Problems with teeth/gums	☐ Bloody Stool	☐ Cold Intolerance
BREAST	**GENITOURINARY**	☐ Heat Intolerance
☐ Breast Lumps	☐ Pain with Intercourse	☐ Excessive Hair Growth
☐ Breast Pain	☐ Spotting with or after Intercourse	
☐ Breast Discharge	☐ Abnormal Vaginal Discharge	
☐ Changes in Skin	☐ Vaginal Dryness	
CARDIOVASCULAR	☐ Urinary Frequency	
☐ Chest Pain	☐ Urinary Urgency	
☐ Heart Palpitations	☐ Urinary Retention	
RESPIRATORY	☐ Painful Urination	
☐ Wheezing	☐ Blood in Urine	
☐ Shortness of Breath	☐ Incontinence	
☐ Cough		

Patient's Signature ______________________ Doctor's Signature ______________________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their protected heath information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I acknowledge that I have received The Center for Women's Rights and Responsibilities policy and have been offered a copy of the entire HIPAA privacy notice. This notice is also available at all times in The Center for Women's waiting room and I may request an additional copy of it at any time by contacting the Office Manager at 330-702-1281.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Work Telephone
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work address
- ☐ Other ______________________

YOU MAY DISCUSS MY HEALTH INFORMATION WITH:

NAME	RELATIONSHIP	PHONE

______________________ ______________________

Patient Signature Date

______________________ ______________________

Printed Name Date of Birth