

GYNECOLOGICAL HISTORY (List problems with your female organs in the past): _____

Date of last pap smear (cancer smear): _____

OBSTETRICAL HISTORY: How many times have you been pregnant: _____

Full Term _____ Premature _____ Multiple Births _____ Stillborn _____ Miscarriage _____ Tubal Pregnancy _____ Now Alive _____

No.	Year	Sex	Wt.	Length Preg.	Length Labor	PROBLEMS

Do you think you are pregnant now? Yes No
 Were any miscarriages complicated by fever? Yes No
 Are you upset about being pregnant? Yes No
 Have any children been released for adoption: Yes No
 Have you tried to become pregnant and been unsuccessful? _____
 What is the age of your oldest / youngest child: _____ / _____

MEDICATIONS: (List all drugs you are taking now): _____
ALLERGIES: (If allergic to drugs list reaction): _____

DO YOU HAVE NOW or HAVE YOU EVER HAD PROBLEMS (list year) WITH:

_____ Skin	_____ Lungs	_____ Bladder	_____ Sinus trouble	_____ Hi blood pres.	_____ Blood Clots	_____ Sensitivity to cold
_____ Glands	_____ Heart	_____ Bones, Joints	_____ Chest pain	_____ Heartburn	_____ Anemia	_____ Always thirsty
_____ Eyes/Vision	_____ Stomach	_____ Muscles	_____ Short Breath	_____ Ulcer	_____ Leg Cramps	_____ Abnormal hair growth
_____ Ears/Hearing	_____ Bowels	_____ Back	_____ Cough	_____ Yellow Jaundice	_____ Bleeding tendency	_____ Dizziness
_____ Nose	_____ Liver	_____ Nerves	_____ Asthma	_____ Hemorrhoids	_____ Thyroid trouble	_____ Lightheaded
_____ Teeth	_____ Gallbladder	_____ Blood	_____ Pneumonia	_____ Arthritis	_____ Diabetes	_____ Fainting spells
_____ Throat	_____ Kidneys	_____ Arteries, Veins	_____ Swollen feet	_____ Varicose Veins	_____ Voice Change	_____ Objects rotating

CHANGE IN: _____ Handwriting _____ Gait _____ Speech _____ Coordination _____ Balance
 Seizures of any kind: _____ Numbness _____ Tingling Other changes in sensation: _____
 Severe headache _____ Weakness in one arm or leg _____

OPERATIONS — including D & C (scraping)	Year	SEVERE ACCIDENTS or INJURIES	Year

STUDIES — list year _____ ECG _____
 X-RAY OF: _____ Chest _____ Bowel _____
 _____ Kidney _____ Gallbladder _____
 OTHER: _____
IMMUNIZATION RECORD: _____ Year _____
INFECTIOUS DISEASES: — List year _____
 _____ German Measles _____ Hepatitis _____
 _____ Poliomyelitis _____ Parasites, worms _____
 _____ Rheumatic fever _____ Mononucleosis _____
 _____ Tuberculosis _____ Venereal infection _____
 Other: _____

FAMILY HISTORY: Have any of your family been affected by one of the following conditions: If yes state the relationship (father, mother, etc.)

_____ Cancer	_____ Heart Disease	_____ Congenital anomalies
_____ Diabetes	_____ Mental Disease	_____ Bleeding tendency
_____ Hi blood pres.	_____ Twins	_____ Hereditary disorder

How do you consider your health in general:
 Excellent Good Fair Poor
 When was your last complete physical and/or gynecologic examination: _____
 have you seen another doctor for your present problem (state name): _____
 If yes, what was his diagnosis, treatment or recommendation _____

SOCIAL HISTORY:
 Occupation(s) past and present: _____
 Education: _____
 Single Married Widowed Divorced
 Number of years married _____ Married more than once _____
 Alcoholic drinks - how much: _____ Cigarettes - how many: _____
 How many hours of daily sleep _____
 Do you get time for relaxation, hobbies, exercise? _____
 Husband — Age _____ Health _____
 Occupation: _____

HEALTH QUESTIONNAIRE FOR OBSTETRICS AND GYNECOLOGY

DATE: _____

The purpose for having you fill out this questionnaire is to obtain an accurate health history. The information obtained in this questionnaire is kept confidential and will not be released except when you have authorized us to do so.

Before filling out the questionnaire we would like you to read it thoroughly and then start answering the questions. For any health problem that has occurred previously it is important to list the year it occurred. Symptoms, problems or questions not marked or answered will be considered not applicable. If you can't remember or if you don't understand the meaning of a question indicate this with a question mark.

NAME _____ AGE: _____ REFERRED BY: _____

ADDRESS: _____ TEL: _____

What is your chief complaint, main problem or reason why you want to be seen:

MENSTRUAL HISTORY:

Last menstrual period (Date or Age) _____
Was last menstrual period of usual amount & duration Yes No
Date of menstrual period previous to last one _____
How many days do your periods last _____
How often do you have a period: _____
Flow: Light Moderate Heavy Excessive
Pain Mild Moderate Severe Excessive
First menstrual period at the age of _____

ABNORMAL MENSTRUAL PERIODS For how long: _____

In regard to: Duration Frequency Flow Pain
Bleeding - Spotting: Before After Between Periods
 After intercourse Completely irregular bleeding

In the week prior to your menstrual period do you experience any of the following symptoms, which at other times are uncommon or less profound and disappear when your period has started:

Irritability Nervousness Depression Abdominal bloating, discomfort Swelling of feet, ankles, face

Headaches Breast tenderness Weight gain

VAGINAL DISCHARGE for how long: _____

Color	Odor	Amount	Consistency	Symptoms
<input type="checkbox"/> White	<input type="checkbox"/> None	<input type="checkbox"/> Little	<input type="checkbox"/> Watery	<input type="checkbox"/> None
<input type="checkbox"/> Yellow	<input type="checkbox"/> Some	<input type="checkbox"/> Moderate	<input type="checkbox"/> Thick	<input type="checkbox"/> Burning
<input type="checkbox"/> Brown	<input type="checkbox"/> Bad	<input type="checkbox"/> Large	<input type="checkbox"/> Mucous	<input type="checkbox"/> Itching

How often do you douche: _____

What method of contraception (birth control) do you and/or your partner use (including vasectomy, tubal ligation, birth control pills, depo provera, etc.?) _____

Side effects? _____

PROBLEMS WITH SEXUAL INTERCOURSE: YES NO

PROBLEMS WITH BREASTS for how long: _____

Lumps: Tenderness: Secretion of milk: Discharge from nipple:

PAIN: (Other than menstrual pain). Where: _____ For how long: _____

ONSET	INTENSITY	NATURE	PROGRESSION		
<input type="checkbox"/> Sudden	<input type="checkbox"/> Severe	<input type="checkbox"/> Sharp	<input type="checkbox"/> Burning	<input type="checkbox"/> Bearing down feeling in pelvic area	<input type="checkbox"/> Constant
<input type="checkbox"/> Rapid	<input type="checkbox"/> Mild	<input type="checkbox"/> Dull	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Feeling of heaviness & fullness in the pelvis	<input type="checkbox"/> Intermittent
<input type="checkbox"/> Gradually	<input type="checkbox"/> Moderate	<input type="checkbox"/> Shooting	<input type="checkbox"/> Crampy	<input type="checkbox"/> Feeling like the female organs would drop out	<input type="checkbox"/> Becoming increasingly worse

What makes it worse: _____

Does it radiate into other areas of the body: _____

What relieves it: _____

Other symptoms associated with it: _____

PROBLEMS WITH URINATING for how long: _____

Painful Sudden urge to urinate
 Frequent Loss of urine with coughing, laughing, walking
 Abnormal Color Unable to empty bladder completely

PROBLEMS WITH BOWEL MOVEMENTS for how long: _____

Diarrhea Abnormal color of stool
 Constipation Pain with bowel movement
 Blood in Stool Difficulty emptying the rectum

APPETITE: Good Poor WEIGHT: Gain Loss How much? _____ NAUSEA VOMITING How long: _____

PROBLEMS WITH Hot flashes Palpitations of heart Night sweats For how long: _____

<input type="checkbox"/> Nervous	<input type="checkbox"/> Difficulty making decisions	<input type="checkbox"/> Guilt feelings	<input type="checkbox"/> Feeling lonely	<input type="checkbox"/> Feel like giving up	<input type="checkbox"/> Difficulty falling asleep/staying asleep
<input type="checkbox"/> Irritable	<input type="checkbox"/> Trouble remembering things	<input type="checkbox"/> Sense of failure	<input type="checkbox"/> Feeling hopeless	<input type="checkbox"/> Depressed	<input type="checkbox"/> Waking up early
<input type="checkbox"/> Excessive worry	<input type="checkbox"/> Loss of interest in social life	<input type="checkbox"/> Marked tiredness	<input type="checkbox"/> Crying often	<input type="checkbox"/> Loss of sexual interest	<input type="checkbox"/> Family problems
<input type="checkbox"/> Feeling frightened	<input type="checkbox"/> Wanting to be alone	<input type="checkbox"/> Loss of energy	<input type="checkbox"/> No ambition	<input type="checkbox"/> Thoughts of ending life	<input type="checkbox"/> Marital problems

OVER

Women's Clinic of North Idaho

980 IRONWOOD DR. STE.#306 COEUR D'ALENE, ID 83814
CDA OFFICE: 208/664-3101 FAX: 208/664-9713

1300 E MULLAN AVENUE #900 POST FALLS, ID 83854
800/562-9608 EXT 2362

PF OFFICE: 208/777-1350

____ FREDERICK P AMBROSE, M.D.
____ MARY A SANDERSON, M.D.
____ STEVEN K WOODS, M.D.

____ PAM HOLCOMB, F.N.P., C.N.M.
____ RONDA WILLIAMSON, C.N.M.
____ LORI NELSON, C.N.P.

Welcome to our Clinic

YOUR APPT DATE AND TIME _____ AT _____ Please arrive 15 minutes early

Patient Information

Please Print and Fill Out Completely

NAME (PRINT PLEASE) FIRST _____ MIDDLE _____ LAST _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ CITY, STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

EMPLOYERS ADDRESS _____ EMPLOYERS PHONE _____

MARRIED _____ YEARS MARRIED? _____ NUMBER OF CHILDREN? _____

SINGLE _____ WERE YOU REFERRED? _____ BY WHAT DOCTOR? _____

UNDER 18 _____

SPOUSE/ PARENT OR PARTNER NAME _____ SOC SEC # _____

THEIR ADDRESS _____

PHONE NUMBER _____ DATE OF BIRTH _____ AGE _____

OCCUPATION _____ EMPLOYER _____

PRIMARY INS. COMPANY _____ 2ND INS. COMPANY _____

MEMBER OR ID # _____ GRP # _____ 2ND ID # _____ GRP# _____

IF EITHER INSURANCE IS UNDER YOUR SPOUSE OR PARENT YOU MUST PROVIDE THEIR DATE OF BIRTH

DATE OF BIRTH OF CARDHOLDER FOR PRIMARY INSURANCE _____ 2ND INSURANCE _____

EMERGENCY CONTACT PERSON (NOT LIVING WITH YOU) _____

RELATIONSHIP _____ PHONE NUMBER _____

DO WE HAVE PERMISSION TO DISCUSS YOUR MEDICAL CONDITION WITH A MEMBER OF YOUR HOUSEHOLD? _____

IF YES, WHO? _____ RELATIONSHIP? _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

I hereby assign all benefits for services by Women's Clinic and include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan and I ask that Women's Clinic furnish all requested medical information of the persons or entity named above if requested by my insurance company in order to process my claim.

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released. This request is a free and voluntary act by me (Statement required by law).

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize Women's Clinic to release all information necessary to secure the payment.

I hereby acknowledge that I am about to incur indebtedness to the Women's Clinic of North Idaho, for professional services rendered and agree to pay all accounts at the time of service unless other prior financial arrangements have been made with the billing department. I understand that outside Radiology, Pathology and Lab services and other consulting or referred physicians will bill me for their own services and I agree to be financially responsible for payment to them for their services.

All accounts are due in full at time services are rendered, unless a payment plan has been agreed upon by our billing department, then the payment amount will be paid monthly, at the agreed upon time of the month. If your insurance is being billed, and your insurance required a co-pay, the co-pay is due at the time of the office visit.

All accounts are due and payable in full within 30 DAYS from the first statement date. In the event that the amount is not paid within 90 days, a finance charge of 1.25% per month on the outstanding balance over 90 days old, which amounts to 15% per year will be added to your account.

We routinely leave appointment reminders and occasionally messages to return a call to our office, so we may call any phone numbers that are on your demographic sheet.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE AND AGREE THERETO.

SIGNATURE _____ / _____ DATE _____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON'S SIGNATURE _____ RELATIONSHIP _____