Date:_____/_____/_____ Name:__________________________ __________________________ DOB: ______________
(Last) (First) (MM/DD/YYYY)

Address:____ City: ________ State: ______ Zip Code: ______

Phone Number: ( ) _______ - __________ Can we leave a voice message/leave a text? □Yes □No

E-mail address: ___________________________

Emergency Contact Name:________________________ Relationship to Patient:_________________________

Emergency Contact Phone Number:_______________

Health Insurance: □Yes □No If yes, what kind? _______________________

Pharmacy Name: __________________________________ Cross Streets: ____

Reason for this visit: ____ First visit? □Yes □No

Medication/Food Allergies? _________________What happens when you take these medications? _____________________

Medications (List all you are currently taking, including over the counter, supplemental):

____

Operations (include year and description, do not include pregnancies): ____

____

Gynecological History

Date of last PAP smear: ___________________ Was it normal? □Yes □No

Ever had an abnormal pap? □No □Yes Year: ________ Any treatment? □Yes □No If yes, when?: ___________

Have you ever had a pelvic infection or a sexually transmitted infection/disease? (Circle all that apply)

None Pelvic Inflammatory Disease Chlamydia Gonorrhea Syphilis Herpes Genital Warts (HPV) HIV

Any treatment? □Yes □No If yes, when?: ___________

Contraception/birth control currently used: ________________ Contraception/birth control previously used: _________________

Date of last mammogram: __________________ Was it normal? □Yes □No

First day of last menstrual period: __________ How long is the duration of your period? _____________

Do you have monthly periods? □Yes □No Is your flow: □light □moderate □heavy?

Severe pain with menses? □Yes □No

Age when periods began? ________________ Any abnormal bleeding? □Yes □No

Do you have PMS? □Yes □No If, yes, is it: □Mild □ Moderate □ Severe?

Circle PMS symptoms that apply: Irritability Breast Tenderness Bloating Cry Easily Headache Fatigue Other:_______________

Do you have symptoms of premenopause? □Yes □No

Do you have any pain or bleeding with intercourse? □Yes □No

Do you have any sexual problems or concerns? □Yes □No

Have you ever had any of the following? □ Biopsy of breast □ Fibroid Tumors □ Ovarian Cysts □ None

Have you ever been concerned with infertility? □Yes □No

Do you perform breast exams? □Yes □No Any abnormalities? □Yes □No

# of sexual partners within the last year: ______

Pregnancy History

Total # of previous pregnancies: _____ Total # of children you have given birth to: _____

Total # of miscarriages: _____ How many weeks pregnant at time of miscarriage(s)?: ___________

Total # of abortions: _____ How many weeks pregnant at time of abortion(s): ___________

- IF APPLICABLE: How do you feel about your past abortion decision? □Regret it □Unresolved □Good Decision □ Resolved

If you were pregnant, what would your intentions be (circle one)? Parent Adoption Abortion Undecided

Please detail all pregnancies in chronological order (including miscarriages, elective abortions), and fill out as applicable:

Year	Vaginal/C-Section/Stillborn Miscarriage/Abortion	Weeks Gestation	Weight	Sex (M or F)	Complications (Diabetes, High Blood Pressure, Ectopic, Breech, etc.)	Birth Date

Social History

Occupation: _________________________ Last year of school completed: ______________ Religion: _____________________

Marital Status: □Single □Married □Living Together □Separated □Divorced □Widowed

Ethnicity (Circle): African American Asian White Hispanic Native American Pac. Islander Other: ________________

Do you exercise regularly? □Yes □No What type?_________________ How often?_______________________

If you are on a restricted diet, please describe: ____

Are you experiencing emotional stress or anxiety? _____Yes _____No Explain:_______________________________

Do/have you ever smoked cigarettes/e-cigarettes/vaping? □Currently Smoking □Previous Smoker □Never Smoked

If so, describe amount and frequency: __________________ Year(s) of tobacco use: _____

Do you drink alcohol? □No □ Yes If so, describe amount and frequency: ____

Do you drink caffeine? □No □Yes If so, describe amount and frequency: ____

Do you use illegal drugs? □No □ Yes If so, describe amount and frequency: ____

Do you use marijuana? □No □ Yes If so, describe amount and frequency: ____

Is blood transfusion acceptable in an emergency? □Yes □No

Do you have a history of blood transfusion, IV drug use, multiple sexual partners, sexual exposure to a gay or bisexual person, exposure to an IV drug user, or have any other reason to believe you may have been exposed to AIDs? □Yes □No

Please list any sources of chemical/radiation exposure that you have encountered: ______________________

Have you ever been physically or sexually abused? □Yes □No Are you currently being abused? □Yes □No

Do you feel that drugs/alcohol are a problem for you? □Yes □No IF YES, Are you interested in becoming clean & sober? □Yes □No

Do you currently have, or have you ever had an eating disorder? □Yes □No

Would you like a referral for a counselor or treatment program? □Yes □No

Patient Name (Printed): ______________________________ DOB: __________

Aid to Women Center is a non-profit medical facility that provides free pregnancy tests, peer consultation, practical assistance, and limited medical services. Trained volunteers and staff members provide tests and peer consultation. The consultation provided is not intended to substitute for professional counseling; a referral for such counseling will be given if indicated. All information is kept confidential, unless clear and present danger to the client or another person is indicated, or any sexual or physical abuse of a minor is reported. NOTE: While the pregnancy test used here is highly sensitive, there are certain medical conditions that could produce a false positive test result; therefore, it is necessary for a Medical Provider to confirm pregnancy. If you do not have a normal menstrual period within the next two weeks a retest and follow-up with a Medical Provider is recommended.

All contact from AWC is held in the highest of confidentiality. When we call you we will ask to talk to you and do not disclose our identity to anyone else but you. However, if a medical condition is indicated, the medical personnel may deem it necessary to contact you by phone or in writing.

I understand I have certain rights to privacy regarding my protected health care information. These rights are detailed in the Notice of Privacy Practices, which is available for my review.

In the event that any disagreement, cause of action, or complaint should arise from the services I receive from this Center I hereby agree to settle any and all disputes through mediation and/or arbitration.

I have read and understand the above statements and, to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the staff of the Aid to Women Center to render whatever services are necessary for my care.

In order for Aid to Women Center to provide you with medical services, we must be able to contact you directly. What is your first preferred method of communication? *□Telephone □Text □E-mail □US postal mail*

Client Signature: × ______________________________ **Date:** ____________________

I, ______________________________ hereby agree to receive the following service(s) from Aid to Women Center:
Name (PLEASE PRINT)

- □ **Medical Services**
  - Includes urine pregnancy tests, serum pregnancy tests, women's health care, and STD/HIV screening for men/women, or basic evaluation by a doctor, nurse, or other qualified personnel.
- □ **Limited Ultrasound**
  - The limited ultrasound study is to determine the viability and age of gestation. I understand that the ultrasound is not for the purpose of diagnosing any medical problem or condition for my baby or myself. I also understand that there is usually no discomfort involved in the ultrasound procedure, although there may be discomfort if a full bladder is needed. (*Because the uterus is confined to the pelvic areas in early pregnancy, the ultrasound may be done abdominally or transvaginally, using a probe which can be easily inserted into the vagina. Ultrasound utilizes high frequency sound waves, and there are no known harmful effects in the twenty-five+ year of clinical use. The possibility always exists that effects may be identified in the future.)*
- □ **Prenatal Services**
  - Includes doctor visits, examinations, laboratory tests, and postpartum visit.

I hereby give Aid to Women Center full consent to any and all procedures performed by AWC medical staff. I waive and release any and all claims, whatsoever kind and nature, that I, my baby, or legal representative or heirs and realities might have or hereafter have against AWC, its practitioner, medical personnel, directors, officers, employees, and volunteers.

I expressly agree that this waiver, release, and indemnity agreement is intended to be as broad and inclusive as permitted by the laws of the state of Arizona, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

______________________________ ____________________
Name (PLEASE PRINT) DOB Telephone Number

× ______________________________ ____________________
Patient's Signature **Date**

______________________________ ____________________
AWC Witness Signature **Date**

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This **Notice of Privacy Practices** identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request accounting and disclosures of your medical information, and request additional restrictions on your uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintain the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the **Notice of Privacy Practices** and is the patient or the patient's personal representative.

____ ________________________________

Name of Patient Signature of Patient

Date Signed: ____________

____ ________________________________

Name of Patient's Personal Representative Signature of Representative

Date Signed: _____________

****

FOR INTERNAL USE ONLY

____ ________________________________

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained

__ Patient was unable to sign

__ Patient refused to sign

__ Other ____

Phone: 480.966.1902 Fax: 480.967.8023

AUTHORIZATION TO RELEASE INFORMATION

I, ______________________________, Date of Birth _______ / _______ / _______,

authorize: ____ Phone: ( ) ________ --- ___________
(please indicate: Doctor name, Hospital name, Facility, etc Fax # : ( ) ________ --- ___________

to **release and/or disclose** my health information to:

Aid to Women Center
1328 E. Apache Blvd.
Tempe, AZ 85281

I understand that:

1) This authorization is voluntary and I may refuse to sign this authorization without affecting my health care or the payment for my health care.
2) I may revoke this authorization at any time by notifying the entity I authorized above in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
3) I understand that nay personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person or organization and may no longer be protected by applicable federal and state privacy laws.

Information to be Disclosed:

□Office Chart Notes	□Most Recent 5 Year History	Other:____________________
□Billing Statements	□History and Physical Exam	________________________
□Laboratory Reports	□Diagnostic Imaging Reports	________________________
□Pathology Reports	□Radiology Reports	________________________
□Consultation	□Operative Reports	________________________

In addition, I authorize that his will include health
□HIV/AIDs infection □Drug/Alcohol abuse □Mental Health □Genetic testing

This authorization shall be effective for 1 year from the date of the signature below. I have fully read and understood the above statement.

____ ________ / ________ / ________
Client's Printed Name Client's Date of Birth

____ ________ / ________ / ________
Client's Signature Date

____ ________ / ________ / ________
AWC Witness Date

1328 E. Apache Blvd
Tempe, AZ 85281
Phone: 480.966.1902 Fax: 480.967.8023

AUTHORIZATION TO RELEASE INFORMATION

I, ________________________________, Date of Birth ______ / ______ / ______,

authorize **Aid to Women Center** to release my records to:

MYSELF

Phone: (   ) ________ --- ___________

Fax #: (   ) ________ --- ___________

This authorization shall be effective for 1 year from the date of the signature below. I have fully read and understand the above statement.

____
Client's Printed Name

_____________________________________ ______ / ______ / ______
Client's Signature Date

_____________________________________ ______ / ______ / ______
AWC Witness Date

1328 E. Apache Blvd
Tempe, AZ 85281
Phone: 480.966.1902 Fax: 480.967.8023

AUTHORIZATION TO RELEASE INFORMATION

I, ________________________________, Date of Birth ______ / ______ / ______,
authorize **Aid to Women Center** to release my records to:

____
(please indicate: Doctor name, Hospital name, Self, etc.)

Phone: (   ) ________ --- ___________

Fax #: (   ) ________ --- ___________

This authorization shall be effective for 1 year from the date of the signature below. I have fully read and understand the above statement.

____
Client's Printed Name

______________________________________ ______ / ______ / ______
Client's Signature Date

______________________________________ ______ / ______ / ______
AWC Witness Date