Aid to Women CENTER

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

Past Personal Medical History

	Yes	No	Year/Description
Anemia	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Autoimmune Disorder (Lupus)	_____	_____	_____
Breast Cancer	_____	_____	_____
Chicken Pox	_____	_____	_____
Clots in Legs/Lungs	_____	_____	_____
Depression/Postpartum Depression	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
Headaches/Migraines	_____	_____	_____
Heart Disease	_____	_____	_____
Hepatitis/Liver Disease	_____	_____	_____
Herpes	_____	_____	_____
High Blood Pressure	_____	_____	_____
History of blood transfusion	_____	_____	_____
HIV	_____	_____	_____
Kidney Disease	_____	_____	_____
Other Neurological Disorders	_____	_____	_____
Rh (D) Sensitized	_____	_____	_____
Recurrent Urinary Tract Infections	_____	_____	_____
Seasonal Allergies	_____	_____	_____
Sickle Cell	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers/Bowel Disease	_____	_____	_____

FAMILY Health History

Have your parents, siblings, aunts/uncles, or grandparents had the following?:

	Yes	No	Relation
Breast Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____
Depression	_____	_____	_____
Diabetes	_____	_____	_____
Endometriosis	_____	_____	_____
Fibroids	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Infertility	_____	_____	_____
Kidney Disease	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Recurrent miscarriage	_____	_____	_____
Uterine Cancer	_____	_____	_____
Other (Please explain)	_____	_____	_____

Are your immunizations up-to-date? Date of last TDAP (tetanus, diphtheria, and Pertussis): _____

Family Planning

Please check any method of contraceptive you have used in the past:

□ Birth Control Pills □ Condoms □ Depo-Provera/other injectable

□ IUD (Intrauterine Device) □ Diaphragm □ Withdrawal □ Spermicide

□ Patch □ Vaginal Ring □ Tubal Ligation □ Vasectomy

□ None □ Other (Describe:_____)

Please check any method of Natural Family Planning you have used in the past:

□ None

□ Sympto-thermal (please circle: CCL Northwest Family Services)

□ Ovulation Method (please circle: Billings FAF Creighton)

□ Calendar/Rhythm

Which method do you currently use? _____

Patient Name (Printed): _____ DOB: _____

Review of Systems

General
- ❑ Fatigue
- ❑ Weight gain
- ❑ Weight loss
- ❑ Fever
- ❑ Hot Flashes

Endocrine
- ❑ Sensitivity to hot
- ❑ Sensitivity to cold
- ❑ Excessive thirst
- ❑ Abnormal hair growth
- ❑ Hair loss

Neuro
- ❑ Headaches
- ❑ Seizures
- ❑ Loss of strength
- ❑ Loss of sensation

Skin
- ❑ Rash
- ❑ Moles (growth/change)
- ❑ Acne

Eyes
- ❑ Visual changes
- ❑ Seeing spots or lights

ENT
- ❑ Sore throat
- ❑ Nasal congestion
- ❑ Earache

Respiratory
- ❑ Cough
- ❑ Difficulty breathing

Heart
- ❑ Chest pain
- ❑ Palpitations

Breasts
- ❑ Breastfeeding
- ❑ Mass or lump
- ❑ Nipple discharge
- ❑ Breast tenderness
- ❑ Perform self-breast
- ❑ Other

Gastrointestinal
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Blood in stool

GYN
- ❑ Vaginal discharge
- ❑ Vaginal burning/pain
- ❑ Vaginal bulge
- ❑ Vaginal/vulvar itching
- ❑ Pelvic pain/pressure
- ❑ Abnormal bleeding
- ❑ Other: _____

Urology
- ❑ Painful/burning urination
- ❑ Blood in urine
- ❑ Leakage or loss of urine

Musculoskeletal
- ❑ Muscle pain
- ❑ Joint pain

Mood
- ❑ Depressed
- ❑ Anxiety
- ❑ Mood Swings

Hematology
- ❑ Easy bruising
- ❑ Frequent nosebleeds

I verify that the information I provided above is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Patient Name (Printed): _____ DOB: _____

FAMILY HISTORY & GENETIC HISTORY

[Note: Please mark your answers carefully. The first column usually indicates family history negative for the genetic problem, while the second column indicates an area of possible concern to be discussed with the doctor.]

Circle one

1. Have either you or the baby's father had a child born with a birth defect? **Yes** **No**
   If Yes, please describe: _____
2. Did either you or the baby's father have a birth defect yourselves? **Yes** **No**
   If yes, please describe: _____
3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (i.e. mental retardation, birth defects, deformities, or inherited disease like hemophilia, muscular dystrophy, or cystic fibrosis.) _____
   _____
   _____
   How is the effected child/person related to you?_____
4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? **Yes** **No**
   If Yes, have either of you had genetic counseling? **Yes** **No**
   If Yes, have either of you had chromosomal studies? **Yes** **No**
   If Yes, where and results?_____
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father is of one of these backgrounds:
   Jewish ancestry? **Yes** **No** If Yes, have you had Tay-Sachs screening tests? **Yes** **No**
   Date: ___ /___ /___ Result: _____
   Black? **Yes** **No** If Yes, have you had Sickle Cell screening? **Yes** **No**
   Date: ___ /___ /___ Result: _____
6. Please indicate if anyone in your family or the baby's father's family has:
   Diabetes **Yes** **No** If yes, how is that person related to you? _____
   Bleeding Disorder **Yes** **No** If yes, how is that person related to you? _____
   Hypertension **Yes** **No** If yes, how is that person related to you? _____
   Cancer **Yes** **No** If yes, how is that person related to you? _____
7. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____
8. Will you be 35 or older at the time the baby is born: **Yes** **No**
9. Will the father be 50 or older? **Yes** **No**

_____ _____ _____ / _____ / _____
Patient Name (Print) Patient Signature Date

PHYSICIAN NOTES ON GENETIC HISTORY: _____
_____
_____
_____
_____

PATIENT NAME: _____ **Supplemental Delivery/Postpartum Record**

Patient Name (Printed): _____ DOB: _____

Aid to Women CENTER

Aid to Women Center is a non-profit agency providing 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 Physician or Nurse Practitioner to confirm pregnancy. If you do not have a normal menstrual period within the next two weeks a retest and follow-up with a Physician or Nurse Practitioner 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 clinic, 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.

Client Signature: ✕_____ **Date:** _____

I, _____ hereby agree to receive the following service(s) from AWC Medical Clinic:
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 utiliizes 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 AWC Medical Clinic full consent to any and all procedures performed by AWC Medical Clinic 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 Medical Clinic, 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, not withstanding, continue in full legal force and effect.

Name (PLEASE PRINT)	**DOB**	**Telephone Number**
×		
Patient's Signature		**Date**
AWC Witness Signature		**Date**

Aid to Women
CENTER

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 _____

Aid to Women
CENTER

APPOINTMENT CONFIRMATION POLICY

Aid to Women Center understands that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible with at least a 48-hour notice. You can cancel appointments by calling the following number: (480) 966-1902.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted 2-3 business days prior to your scheduled appointment. If we do not get a confirmation of your appointment, your appointment will be cancelled.

PLEASE REVIEW THE FOLLOWING POLICY:

- Please cancel your appointment with at least a 48 hours' notice: There is a waiting list to see the providers at Aid to Women Center and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

- If we do not receive confirmation from you 48 hours in advance, your appointment will be cancelled and given to one of our patients on our waiting list.

I have read and understand Aid to Women Center's Appointment Confirmation Policy and understand my responsibility to plan appointments accordingly and notify Aid to Women Center appropriately if I have difficulty keeping my scheduled appointments.

_____ ___ / ___ / ___

Patient Name Date of Birth Date

_____ ___ / ___ / ___

Staff Signature Date

Aid to Women CENTER

Prenatal Package Agreement and Consent

I am electing to participate in the Aid to Women Center prenatal package. By **initialing each item** and signing below, I hereby agree to the following:

_____ I consent to full prenatal care by Aid to Women Center Pregnancy and Medical Clinic (AWC).

_____ I agree to follow appropriate guidelines and recommendations for prenatal care, as instructed by AWC physicians, I agree to follow up with AWC physicians or recommended specialists as directed. I will not hold AWC responsible for any liability of care if I am noncompliant in my care.

_____ I consent to all standard testing in pregnancy, including the following lab work: blood and urine collection for prenatal testing, pap smear, GBS, and STD testing, including but not limited to, HIV, Syphilis, Chlamydia and Gonorrhea.

_____ I consent to prenatal ultrasounds, as directed by the physician, to include at least one Level I ultrasound (to be performed at approximately 21 weeks). I understand that additional ultrasounds may be ordered or requested, and I am financially responsible for additional expenses as they occur.

_____ I understand that AWC offers limited services, specifically those relating to women's health and pregnancy. Appointment days and times may be limited, but proper care schedules will be routinely followed by AWC, unless other arrangements are made. I understand that certain high-risk conditions may not be manageable by AWC, and I may be referred to an outside provider should I require such care. I understand that after hours and emergency care are **not** available through AWC. Proper procedures in case of an emergency will be discussed throughout my pregnancy, however I am ultimately responsible for seeking appropriate emergency care as needed.

_____ I understand that AWC physician do not perform deliveries. Arrangements may be coordinated with the assistance of AWC; however, delivery arrangements are ultimately my responsibility.

_____ I consent to the release of my records to outside professionals, (i.e., specialty physicians, nutritionists, pediatrics, perinatologists) as needed for proper care of myself and my child, as well as to the hospital I have selected for delivery.

_____I understand the cost of my Prenatal Package is $ 385

_____ I understand that should additional testing, treatment, or care be required, additional costs may be incurred. These costs will be discussed prior to service whenever possible. Additional costs are my responsibility, and are generally due at the time service is rendered, unless other arrangements are made.

_____ I understand that the package cost should be paid in full by the 36th week of my pregnancy. I agree to make regular payments toward the balance of my account. If I am unable to make regular payments, I will discuss my situation with the proper AWC staff and make appropriate arrangements for my package and payments.

_____ I understand that I am free to transfer care at any time during my pregnancy. If I choose to transfer care, I understand I am responsible for payment on any services already rendered. If I have made advance payments toward the package, I may be entitled to partial reimbursement. However, costs already incurred, including lab costs, and other fees for rendered services may apply. I understand that $140 is non refundable if prenatal labs have been performed.

Name _____ Signature _____ Date _____ / _____ / _____

AWC Witness _____ Date ____ / ____ / ____ Entered in Ledger? **Y N** Date: ___ / ___ / ___ Initials: _____

Aid to Women CENTER

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