Date:_____/_____/_____Name:____/_______
Last First Date of Birth / Age

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

Phone Number: ( ) _______ - __________ Can we leave a message? ☐Yes ☐No E-mail: ___________________________

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*

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):

____

Operations (include description and year, 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? ____________________________________

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

Pelvic Inflammatory Disease Chlamydia Gonorrhea Syphilis Herpes Genital Warts (HPV) HIV

Did you receive treatment?_________

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: __________ Is your flow ☐light/ ☐moderate/ ☐heavy?

How long do your menses last? _____________ Severe pain with menses? ☐Yes ☐No

Do you have monthly periods? ☐Yes ☐No

Age when periods began? _________________ Any abnormal bleeding? ☐Yes ☐ No

Do you have PMS? ☐Yes ☐No If, yes (circle one): Mild/Moderate/Severe

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

Do you have symptoms of pre-menopause? ☐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

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

Do you perform self breast exams? ☐Yes ☐No Any abnormalities? ☐Yes ☐No

# of sexual partners within the last year: ______

Aid to Women
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Pregnancies:

\# of previous pregnancies_____ # of children you have given birth to_____
\# of miscarriages______ # weeks pregnant at time of miscarriage______
\# of abortions______ # of weeks pregnant at time of abortions___________
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

Pregnancy Information

Birth Date	C-Section/Vaginal Miscarriage/Abortion/Still born	Weeks Gestation	Weight	Sex (M/F)	Complications (diabetes, high blood pressure, etc)

Social History

Occupation: ____________________________ Last year of school completed: ________________________
Marital Status (circle one): Single Married Living Together Separated Divorced Widowed

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

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? ☐Currently Smoking ☐Previous Smoker ☐Never Smoked Years of tobacco use ________

How often do you smoke? __________________ Do you drink alcohol? ☐Yes/How often_____________________ ☐No

Do you drink caffeine? ☐Yes/How often _____________________ ☐No

Do you use drugs? ☐Yes/How often _____________________☐No

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

Do you have a history of blood transfusion, IV drug use, multiple sexual partners or 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

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, not withstanding, 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 ____