Aid to Women CENTER

Date: _____ / _____ / _____ **Name**:_____ _____ _____
Last **First** **Date of Birth / Age**

Address:_____ **Phone Number**: ( ) _____ - _____
City: _____ **State**: _____ **Zip Code**: _____ **Can we leave a message?** □Yes □No
Can we send letters? □Yes □No **E-mail**: _____
Marital Status (circle one): Single Married Living Together Separated Divorced Widowed **Spouse's Name**:_____
Emergency Contact Name:_____ **Relationship to Patient:**_____ **Phone Number:**_____
Health Insurance: □Yes □No **If yes, what kind?** _____
Last year of school completed: _____ **Occupation**:_____
Ethnicity (Circle): African American Asian White Hispanic Native American Pac. Islander Other: _____
Religion:_____ **First visit**? □Yes □No
How did you hear about us (circle one)?: Friend/Family Internet Clinic/Dr. Advertisement Sidewalk Sign Other: _____
Reason for this visit: _____

Medication/Food Allergies?_____ **What happens when you take these medications?**_____
Medications (List all you are currently taking, including over the counter):_____
_____
Hospitalizations/Operations (include description and year, do not include pregnancies):_____
_____

Date of last PAP smear: _____ **Was it normal**? □Yes □No
Ever had an abnormal pap? □No □Yes **Year**:_____ **Any treatment?**_____
Do you perform breast exams? □Yes □No **Any abnormalities?** □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
Do you have PMS? □Yes □No **If, yes (circle one):** Mild/Moderate/Severe
Circle PMS symptoms that apply: Irritability Breast Tenderness Bloating Cry Easliy Headache Fatigue Other_____
# of sexual partners within the last year:_____ **Contraception/birth control currently/previously used**:_____
Have you ever had a pelvic infection or a sexually transmitted disease? (Circle all that apply) **Did you receive treatment?**_____
Pelvic Inflammatory Disease Chlamydia Gonorrhea Syphilis Herpes Genital Warts (HPV) HIV

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

Year	C-Section/Vaginal Miscarriage/Abortion /Still born	Weeks Gesta-tion	Weight	Sex (M/F)	Complications (diabetes, high blood pressure, etc)

Have you ever been physically or sexually abused? □Yes □No
Are you currently being abused? □Yes □No
Are you experiencing emotional stress or anxiety? _____Yes _____No **Explain:**_____
Do you smoke cigarettes? □Yes □No **Do you drink alcohol?** □Yes □No **Do you use drugs?** □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 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.

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 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**

For Office Use Only

Test Results:_____ LMP:_____ Gestational Weeks:_____ EDC:_____Tester:_____

Notes:_____