



Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MM/DD/YYYY) DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_ Can we leave a voice message? Yes No Text? Yes No Email? Yes No

E-mail address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

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

Health Insurance: Yes No If yes, what kind? \_\_\_\_\_ Please note: We are cash pay only and do not accept any insurance.

Pharmacy Name: \_\_\_\_\_ Cross Streets: \_\_\_\_\_

Medication/Food Allergies? \_\_\_\_\_ What happens when you take these medications? \_\_\_\_\_

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

Reason for this visit: \_\_\_\_\_ First visit? Yes No

### **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:  Birth Control Pills  Condoms  Depo-Provera/other injectable  IUD (Intrauterine Device)  
 Diaphragm  Withdrawal  Spermicide  Patch  Vaginal Ring  Tubal Ligation  Vasectomy  Nexplanon/subdermal implant  
 Plan B/emergency contraception  None  Natural Family Planning ( Calendar/Rhythm  Sympto-thermal [please circle: CCL Northwest Family Services]  Ovulation Method [please circle: Billings FAF Creighton])  Other (Describe: \_\_\_\_\_)

Date of last mammogram: \_\_\_\_\_ Was it normal? Yes No

Have you ever had a biopsy of your breast? Yes No

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

Are you sexually active? Yes No # of sexual partners within the last year: \_\_\_\_\_

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?  Fibroid Tumors  Ovarian Cysts  None

**Obstetrical History**

Total # of previous pregnancies: \_\_\_\_\_ Total # of children you have given birth to: \_\_\_\_\_ Total # of children you have at home: \_\_\_\_\_

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

**Past Pregnancies**

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

**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? Yes No Date of last TDAP (tetanus, diphtheria, and Pertussis): \_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_ Last year of school completed: \_\_\_\_\_ Religion: \_\_\_\_\_

Marital Status: Single Married Living Together Separated Divorced Widowed

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 use marijuana?  No  Yes If so, describe amount and frequency: \_\_\_\_\_

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

Do you use IV drugs?  No  Yes If so, describe amount and frequency: \_\_\_\_\_

Do you drink caffeine?  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, exposure to an IV drug user, or have any other reason to believe you may have been exposed to AIDs?  Yes  No

What is your current housing status?  homeless  lives in own home  other \_\_\_\_\_

Are there any guns present in your home?  Yes  No

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

Do you feel safe in your home?  Yes  No

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)	_____	_____	_____
Cancer	_____	_____	_____
Chicken Pox	_____	_____	_____
Clots in Legs/Lungs	_____	_____	_____
Depression/Postpartum Depression	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
Headaches/Migraines	_____	_____	_____
Hearing/Ear Problems	_____	_____	_____
Heart Disease	_____	_____	_____
Hepatitis/Liver Disease	_____	_____	_____
Herpes	_____	_____	_____
High Blood Pressure	_____	_____	_____
History of blood transfusion	_____	_____	_____
HIV	_____	_____	_____
Infertility	_____	_____	_____
Kidney Disease	_____	_____	_____
Other Neurological Disorders	_____	_____	_____

Polycystic Ovarian Syndrome	_____	_____	_____
Rh (D) Sensitized	_____	_____	_____
Recurrent Urinary Tract Infections	_____	_____	_____
Seasonal Allergies	_____	_____	_____
Sickle Cell	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers/Bowel Disease	_____	_____	_____

Hospitalizations/Operations/Procedures (do not include pregnancies):

Year \_\_\_\_\_ Description \_\_\_\_\_

Year \_\_\_\_\_ Description \_\_\_\_\_

Year \_\_\_\_\_ Description \_\_\_\_\_

Year \_\_\_\_\_ Description \_\_\_\_\_

**Review of Systems** (Please mark any symptoms you have)

**General**

- Fatigue
- Weight gain
- Weight loss
- Fever
- Hot Flashes
- Night Sweats

**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
- Ear pain

**Respiratory**

- Cough
- Difficulty breathing

**Heart**

- Chest pain
- Palpitations

**Breasts**

- Breastfeeding
- Mass or lump
- Nipple discharge
- Breast tenderness
- Perform self-breast exams
- 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

**Other** \_\_\_\_\_

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

Patient 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  
Date Signed: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Name of Patient's Personal Representative  
Date Signed: \_\_\_\_\_

\_\_\_\_\_  
Signature of Representative

\*\*\*\*\*

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 \_\_\_\_\_



**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 Phone: 480.966.1902  
3029 N. Alma School Rd. Ste 130 Fax: 480.967.8023  
Chandler, AZ 85224

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:**

- |   |   |              |
|---|---|--------------|
| <input type="checkbox"/> Office Chart Notes | <input type="checkbox"/> Most Recent 5 Year History | Other: _____ |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> History and Physical Exam  | _____        |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Diagnostic Imaging Reports | _____        |
| <input type="checkbox"/> Pathology Reports  | <input type="checkbox"/> Radiology Reports          | _____        |
| <input type="checkbox"/> Consultation       | <input type="checkbox"/> Operative Reports          | _____        |

In addition, I authorize that his will include:

- 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.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
AWC Witness

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date



3029 N. Alma School Rd. Ste. 130  
Chandler, AZ 85224  
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.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
AWC Witness

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date



3029 N. Alma School Rd. Ste. 130  
Chandler, AZ 85224  
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, family member, 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.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
AWC Witness

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date