Women's Medicine Collaborative
A program of The Miriam Hospital
Lifespan. Delivering health with care.™

146 West River Street
Providence, RI 02904
3rd Floor
(401) 793-7010
WomensMedicine.org

Dear ____,

Welcome to **Women's Primary Care**.

Your appointment is on ___________________________ with ____.

Women's Primary Care is located on the Third (3rd) floor.

Please arrive at ____________________ am/pm.

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.
Please do not mail your packet back to us.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.

Please Note: If you arrive later than 15 minutes for your appointment, you may have to reschedule your appointment.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

For more information about the Women's Medicine Collaborative, please visit our website at *www.WomensMedicine.org.*

We look forward to seeing you.

Sincerely,
Women's Primary Care

"Helping women reach their greatest health potential in body, mind, and spirit."

Women's Medicine Collaborative

A program of The Miriam Hospital

A Lifespan Partner

146 West River Street Providence, RI 02904

DRIVING DIRECTIONS

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 146 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

BUS ROUTES

Best services to take are **Route# 58** to Corliss Street and West River Street or **Route# 72** to Charles Street and West River Street.

Route# 58: Get off at bus stop near Stop & Shop. Walk down the hill to the corner of Corliss Street and West River Street, take a right onto West River Street. Our building is a brick mill building on the right. Enter through the South parking lot entrance.

Route# 72: Get off at bus stop in front of the Providence Post Office (across the street from the "Subway" sandwich shop). Walk to the corner of Charles Street and West River Street, take a right onto West River Street and walk straight down to our building. It is a brick mill building on the left. Enter through the South parking lot entrance.

Contact RIPTA at (401) 781-9400 or online at www.ripta.com for schedules and additional information.

Women's Medicine Collaborative*

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*The Miriam Hospital d.b.a. Women's Medicine Collaborative

146 West River Street
Providence, RI 02904

Tel 401 793-5700
Fax 401 793-7801

About Your Billing

To our patients:

This letter is to give you notice that the Women's Medicine Collaborative is an out-patient department of The Miriam Hospital. It is not a private doctor's office.

Because we are part of the hospital system, you may be responsible for two charges - a facility fee and a fee for physician or other licensed professional services.

You are responsible for all copayment, coinsurance, or deductible payments according to your insurance plan.

We cannot predict the total out-of-pocket expense you will have for your visit. You are strongly encouraged to contact your insurance company prior to your office visit or procedure to understand your responsibility for any copayment, coinsurance, and/or deductible. Your copayment is due at the time of the visit.

Please also ask your insurance company if a referral or prior authorization is necessary.

If you have any questions, please contact our office at (401) 793-5700.

Sincerely,
The Miriam Hospital
doing business as Women's Medicine Collaborative

Definitions

Facility fee: A facility fee is a legally mandated charge for services given in a hospital-based out-patient department. This is also called "provider-based billing", which is a service charge for the patient's use of the hospital's facility, equipment, and support services.

Copayment (Copay): A fixed amount ($20, for example) you pay for a health care service. Copayments can vary for different services within the same insurance plan, like medications, lab tests, and visits to specialists.

Deductible:
The amount you pay for health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of health care services yourself. After you pay your deductible in full, you usually pay only a copay or coinsurance for covered health care services. Your insurance company pays the rest.

Coinsurance: The percentage of the cost of a health care service that you must pay (20%, for example) after you've paid your deductible. For example, if you've paid your deductible in full, and the cost of the service is $100, you must pay 20% of $100, or $20. The insurance company pays the rest.

Women's Medicine Collaborative
Lifespan. Delivering health with care.

New Model of Primary Care for Women
A focus on Wellness

Welcome to Women's Primary Care! We look forward to caring for you.

As health care has adapted to necessary changes in care delivery during the Covid-19 pandemic, we recognize more than ever the value of innovative ways of delivering care. Women's Primary Care is excited to share with you our new model of care. Consistent with our mission to help you achieve your greatest health potential in body, mind, and spirit, we are proud to be on the cutting edge of modern health care delivery.

Because so many of our patients have told us they love the option of telemedicine, we are incorporating telemedicine into our practice long-term. However, not all visits can be safely done via a phone call or video visit. In our new model of care, we anticipate that most patients will have one Chronic Care visit and one Wellness visit each year, with Targeted visits as needed for specific medical problems and urgent concerns.

Wellness Visit: All patients will have an in-person wellness visit within a 16-month time period. The wellness visit is intended to focus on prevention of disease and your overall health and well-being. At this visit, the provider will do important health screenings, immunizations, and a physical exam. There will be more time to discuss important aspects of health such as healthy eating, physical activity, stress management, sleep, and relationships. Most insurance plans cover this visit without a co-pay.

Chronic Care Visit: Your provider will review your medical conditions and discuss an individualized plan of care. Good control of chronic conditions such as high blood pressure, diabetes, and asthma, is the key to maintaining optimal health. This visit may be an in-person office visit **or** it may be a telemedicine appointment during which you speak with your provider by telephone or video call.

Targeted Visit: This is a brief visit to address a specific issue. This visit type may be used for a brief follow-up such as a blood pressure check or to review test results or to see if a new treatment is effective. This may be an in-person visit or a telemedicine appointment during which you speak with your provider by telephone or video call. This visit type is also used for what many call a "sick visit". If you have a new or urgent medical problem, please call the office. We can generally accommodate you that same day. Every effort will be made to have you seen by your primary care provider (PCP). If your PCP is unavailable, you will be scheduled with another provider of our care team.
If you are experiencing a medical emergency, please call 911.

Co-pays: Because insurance plans vary, as with any medical visit, it is the patient's responsibility to check with their insurance provider to see what is covered under their plan. Patients should confirm their coverage prior to the visit to understand if there will be a co-pay and any additional out of pocket expense.

We understand you may have questions. Please see the back of this page for answers to some of the most frequently asked questions (FAQs).

Please feel free to call the office with any concerns or questions (401) 793-7010.

We look forward to seeing you soon.

Innovative New Model of Primary Care: A focus on Wellness
Frequently Asked Questions

What is telemedicine? Over the past two decades, many smartphone users have taken advantage of technology to interact with friends and family and even work related meetings. Many use FaceTime and Skype as ways to interact with family and friends rather than just speaking by phone. This technology has expanded to the field of medicine in the form of telemedicine (or telehealth). Using a phone, smartphone, tablet or computer, a patient can connect with a health care provider for medical advice. Telemedicine offers new opportunities and benefits to our patients. For some, rather than multiple visits to the office, follow up discussions with their provider have been held using telemedicine. Telemedicine also removes barriers for those with transportation or childcare issues.

While in-person care will always be part of health care, and is often preferred, telemedicine has expanded the services we can provide to our patients. Patients have been pleased with telemedicine appointments and report feeling connected, listened to, and satisfied with the care they have received.

Is a telemedicine appointment covered by insurance? Because insurance plans vary, as with any medical visit, it is the patient's responsibility to check with their insurance provider to see what is covered under their plan. Patients should confirm their coverage prior to the visit to understand if there will be a co-pay and any additional out of pocket expense.

What if I am scheduled for a Wellness Visit, but have developed a new symptom or want to discuss a chronic condition? A Wellness Visit is a preventative health care appointment. Preventative health care aims to maintain wellness and prevent health problems before they occur. If you have concerns about a new symptom or a chronic condition, just let us know before the visit. We can schedule a separate Chronic Care or Targeted Visit. If your concerns are more urgent, we can convert your Wellness Visit to a Chronic Care or Targeted Visit and reschedule the Wellness Visit for another time. Our goal is to dedicate the Wellness Visit to "health" care and not "sick" care.

Do I need a Wellness Visit and a Chronic Care Visit? Why can't I just do everything at one visit? The focus of each visit is very different. If you have chronic medical conditions, we feel it is important to see a health care provider at least twice a year. If your chronic condition or symptoms are not well controlled, you will likely need more visits. This new model of care gives you the opportunity to see your provider as much as needed to maintain good control of your health, but also dedicates time for preventative health care and health care maintenance. Women without any chronic medical conditions may only need a Wellness Visit. Your provider will recommend the best visit type based on your medical history.

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GENERAL OFFICE POLICIES

Welcome to our practice! Thank you for choosing Women's Primary Care. We are committed to providing each patient with comprehensive personalized and professional care. We hope the following information will answer some of your questions and help you understand how our office operates.

Office Hours
We are open Monday through Friday. Phone calls are answered by our care team Mon. through Fri. 8:30am - 4:30pm.

After Hours
An on-call provider is always available after hours for urgent medical questions. Prescription refills, appointment scheduling/cancellation, and lab/test results should be handled during routine office hours only. If you have a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Patient Portal
MyLifespan is a secure, password protected site. The portal provides you with access to many components of your medical record including lab results, immunizations, upcoming appointments, and you can use the portal to contact your provider. The portal should never be used to communicate urgent matters. Please call the office.
You can sign-up for the patient portal at your next appointment or go to www.lifespan.org/mylifespan

Scheduling Appointments
Appointments can be scheduled by phone, in person, or by requesting a non-urgent appointment using the MyLifespan patient portal. We do not offer walk-in appointments. If you are experiencing a medical emergency, please call 911.

MyLifespan patient portal appointment requests are available for non-urgent matters. The office will respond to your request in 48 hours. If you are looking for a same day appointment, you must call the office. Every effort will be made to have you seen by your assigned provider, but if unavailable, you will be scheduled with another member of our team.

Patients arriving later than 15 minutes for their appointment or without paperwork completed, may be rescheduled. Please contact the office as soon as possible if you cannot make your appointment time.

Our Model of Care
We offer virtual visits! As health care adapted to necessary changes during the Covid-19 pandemic, our patients shared with us how much they enjoyed the telemedicine option. When appropriate, we offer telemedicine appointments for added convenience – no need to find childcare, get stuck in traffic, or leave your home. We bring the appointment to you! See the enclosed description of visit types. If you prefer a virtual visit, let us know.

Cancellation Policy
We realize patients may need to change their appointments. We kindly request 24-hour notification of cancellation for appointments so we may offer that time to another patient. A cancellation less than 24 hours before an appointment is considered a "no show". If you have three (3) "no shows" you may be dismissed from the practice.

Medication Refills
You are generally prescribed enough medication to last until your next scheduled appointment. Medications (other than narcotics, stimulants, benzodiazepines, and sleep aids) will be approved for a refill if you are a current patient actively in treatment with a prescribing provider. Actively in treatment is defined as having had at least one (1) visit in the past twelve (12) months.

~ Continued on Back ~

Check your prescription bottle or with your pharmacy to see if additional refills are already authorized. Your pharmacy will most often contact our office for routine refills. If additional refills are not authorized, please have your pharmacy send an electronic refill request to us directly.

We ask that you provide us with at least 3 working days for refill requests.

If you require a new medication, please contact our office via the patient portal or by telephone.

Controlled Substances

We are working hard to ensure that controlled substances are prescribed in the safest manner possible. For this reason, we do not prescribe controlled medications such as narcotics, stimulants, benzodiazepines, or sleep aids at your initial visit. We need to obtain prior medical and pharmacy information to prescribe these medications. Controlled substances will be refilled based on the below criteria:

a. Narcotics and Stimulants: the patient must attend an appointment every three (3) months unless otherwise agreed to by the patient and provider.
b. Benzodiazepines and Sleep Aids: the patient must attend an appointment every six (6) months unless otherwise agreed to by the patient and provider.

Antibiotics

It is our policy that we do not prescribe antibiotics over the phone. We feel it is important to include a physical exam in the decision to prescribe these medications. For this reason, we will make every effort to see patients for sick visits quickly.

Test Results

All test results will be communicated through the MyLifespan patient portal, by mail, or by telephone as appropriate. To sign-up for the MyLifespan patient portal go to: www.lifespan.org/mylifespan

Medical Forms

We do not charge a fee for completing health-related forms. However, please contact your provider in advance and allow **7 working days** for the completion of any forms. You may need an appointment to complete your form. If so, you are responsible for any co-pay.

Insurance Referrals

Please allow **7 working days** for us to complete an insurance referral.

Insurance

If you plan to switch your medical insurance to a different carrier, please call us first to verify that we are participating with your new plan.

We Are an Academic Practice

An academic practice means that our physicians are faculty at Brown University's Internal Medicine Residency program as well as The Warren Alpert Medical School and that our nurse practitioners are instructors at local nursing schools. We often have medical students, nurse practitioner students, and resident physicians working in our office. Resident physicians have their medical degree and are completing their training in internal medicine. Your provider will always see you during the visit, but please let us know if you are uncomfortable seeing a student or resident physician.

Research

As women have been historically underrepresented in clinical research, our team thrives to research various disorders in women to find answers and provide evidence-based quality care; and lead the way in advancing the care of women. Knowledge starts with you! You may be contacted to participate in a research study and to check your eligibility for ongoing studies. Participation in research is always voluntary; however, it is greatly appreciated. You may contact us at **(401) 793-7398** or email **WMCResearch@lifespan.org** if you're interested in learning more about our ongoing studies or to check whether you may qualify for any of our ongoing studies.

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Deciding when to go to the Emergency Room

An on-call physician is available 24/7 to help guide your decision to go to the ER or not. Call 793-7010 and you will be directed to the Call Center.

Call 911 or Go to the ER

- Major injuries (broken bones)
- Uncontrolled bleeding
- Coughing or vomiting blood
- Sudden severe pain
- Poisoning
- Sudden facial drooping or weakness in an arm or leg
- Difficulty breathing
- Fainting
- Chest pain or pressure

Call for a "Sick Visit" 793-7010

- Flu symptoms
- Fever
- Earache
- Sore throat
- Non-life-threatening illness or injury

Call for a Routine Appointment 793-7010

- Check-up/Annual visit
- Vaccinations/Immunizations
- Discuss starting a new medication
- Discuss symptoms that don't seem to be going away

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146 West River Street, Providence, RI 02904

Patient Label

REGISTRATION FORM (PLEASE PRINT)

Legal Last Name	Legal First Name	Middle
Preferred Name	Email	
Birth Date / Social Security #	Religion	

Street Address			Home Phone ( )
City	State	Zip Code	Mobile Phone ( )

Marital Status	Preferred Language
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Significant Other ❑ Other:______________	Spoken ____________________ Written ________________ Interpreter Required? ❑ YES ❑ NO
Sex: ❑ Female ❑ Male ❑ Transgender	Pronouns

Preferred Pharmacy: Name: Phone #:
Address:

Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time
❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time

Employer	Occupation	Employer Phone ( )
Which provider you are here to see today?	How did you hear about us?	

Primary Care Provider (PCP) / Practice Name	
PCP Address	PCP Phone ( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )
Is this patient covered by insurance? ❑ Yes ❑ No	Primary Insurance Plan Name		
Group #	Policy #	Co-Pay Amount	
Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________	
Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer		

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #
Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________	Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer	

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

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*The Miriam Hospital d.b.a. Women's Medicine Collaborative

Name:
DOB:
MRN:

ETHNICITY – PLEASE SELECT

We want to make sure that all our patients get the best care possible.
Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer

RACE - PLEASE SELECT

❑ Unknown

❑ Prefer not to answer

❑ American Indian or Alaska Native

❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)

❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)

❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)

❑ White or Caucasian

❑ Other: ______________________________

PHONE PRIVACY

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME telephone # (________) ______________________

MOBILE telephone # (________) ______________________

WORK telephone # (________) ______________________

BEST number to reach you: ❑ Home ❑ Mobile ❑ Work

May we leave a **general** message about appointments?
HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

May we leave a **detailed** message?
HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

The Miriam Hospital
Lifespan. Delivering health with care.®

The Miriam Hospital
Health Information Management
164 Summit Avenue, Providence, RI 02906
Ph) 401-793-2222 Fax) 401-793-2247

Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name____________________ DOB__________ Phone ____________

Address ____
Street City State ZIP

1. I hereby authorize the Women's Medicine Collaborative: A program of The Miriam Hospital to:

☐ Release to and/or ☐ Obtain from (please indicate)

2. ______________________________ ______________
Person /Place/Institution Phone Number

______________________________ ______________
Street City State Zip Fax Number

3. Dates of treatment or time period: ________________________

4. Purpose for which disclosure is to be made: ☐ Coordination of Care ☐ Patient Request ☐ Legal

☐ Other (please specify): ____________________

5. Record Format-please check one: ☐ Paper ☐ Data Storage Device

6. Information to be disclosed (check all applicable): *There may be a fee associated with this request.*

☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab/X-ray Reports ☐ Other Diagnostic Testing

☐ Clinic/Office Visit ☐ Consultation/Evaluation ☐ After Visit Summary

☐ Abstract* ☐ Discharge Summary ☐ Other____________________

*Abstract includes: Facesheet, ED Record, H & P, D/C Summary, Consult, Operative report, Pathology report, test results, PT/OT/ST

For Behavioral Health Affiliates: ☐ Assessment ☐ Treatment Plan ☐ Psychiatric Evaluation ☐ Medications

7. I do not want the following information disclosed: ☐ Mental Health ☐ Alcohol/Drug Use/Test

☐ Sexual Abuse ☐ Sexually Transmitted Infections ☐ AIDS/HIV Test Results

8. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.
9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan, its employees and my physicians from all liability arising from this disclosure of my health information.
10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Lifespan in writing. I understand that any previously disclosed information would not be subject to my revocation request.
11. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

______________________________ ______________
Signature of Patient*, Legal Guardian, or Representative Date Time

______________________________ ______________
Print name of Patient, Legal Guardian or Representative Date Time

*Note Concerning Minors: For disclosures to persons/entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV & venereal disease) or for alcohol and/or drug abuse treatment is required.

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Women's Primary Care
146 West River St., Providence, RI 02904
3rd Floor ~ Suite 11D
(401) 793-7010

Name:

DOB:

MRN:

PLEASE FILL OUT ALL FORMS AND BRING TO APPOINTMENT

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name:______________________ First:______________ DOB: ______________

Preferred Name: ______________________ Preferred Pronouns: ______________________

Other Physicians

Obstetrician/Gynecologist ______________ Endocrinologist ______________________

Gastroenterologist______________________ Other ______________________________

Dermatologist__________________________ ______________________________

Screening and Prevention

Last Physical Exam: Date ______________ Physician/NP: ______________________

Last Cholesterol test Date________ Testing facility ______________________ □ Normal □ Abnormal

Last Colonoscopy Date________ Testing facility ______________________ □ Normal □ Abnormal

Last Mammogram Date________ Testing facility ______________________ □ Normal □ Abnormal

Last Pap Smear Date________ Testing facility ______________________ □ Normal □ Abnormal

Last Bone density test Date________ Testing facility ______________________ □ Normal □ Abnormal

Last Stress Test Date________ Testing facility ______________________ □ Normal □ Abnormal

VACCINES:

Measles/Mumps/Rubella Date________ Testing facility ______________________

Hepatitis B Date________ Testing facility ______________________

Tetanus Date________ Testing facility ______________________

PPD test Date________ Testing facility ______________________

Flu Date________ Testing facility ______________________

Pneumonia Date________ Testing facility ______________________

HIV screening is now recommended for all individuals. Have you ever been tested for HIV? □ Yes □ No

Past Medical History (please check all that apply) □ High Blood Pressure □ Diabetes (including gestational)

□ Stroke □ High cholesterol □ Heart Attack □ Asthma □ Pneumonia

□ Emphysema □ Tuberculosis □ Kidney Disease □ Thyroid Disease □ Ulcers

□ Liver Disease □ Alcohol problems □ Depression □ Anxiety □ Migraine

□ Arthritis □ Osteoporosis □ Fractures □ Bleeding Tendency □ Anemia

□ Blood clot □ Seizure □ Frequent UTIs □ Sexually transmitted disease

□ Ovarian cysts □ Fibroids □ D.E.S. exposure

□ Cancer: type______________________ □ Other ______________________________

Prior Hospitalizations/Surgeries: ______________________________________

____

Have you ever received a blood transfusion? □ Yes □ No If yes, year ______________

Have you had a hysterectomy? □ Yes □ No If yes, reason______________

Were your ovaries removed? □ No □ Yes (one) □ Yes (both)

List all ALLERGIES: **Medication/Food** **Reaction**

______________________________ ______________________

______________________________ ______________________

______________________________ ______________________

______________________________ ______________________

Name:

DOB:

MRN:

List all MEDICATIONS (please include non-prescription drugs)

Name	Dose	Frequency

Family History	AGE	Health Status	Age at Death	Cause
Father				
Mother				
Brothers/Sisters				
1.				
2.				
3.				

Do you know of any blood relative who has or had: □ Diabetes □ Heart Attack □ High Blood Pressure
□ Stroke or Blood Clot □ Tuberculosis □ Asthma □ Thyroid disease □ Kidney disease
□ Liver disease □ Cancer: Type__________ □ Depression □ Alcoholism □ Bleeding disorder

Lifestyle and Personal Habits

Who do you live with at home? ______________________ Your occupation________________________________

Do you/have you ever smoked? □ Yes □ No If yes, _____ packs/day for _____yrs Quit date ________

Do you drink alcohol? □ Yes □ No If yes, number of drinks/week ___________________

Do you use any recreational drugs? □ Yes □ No If yes, what type? ___________________

Do you exercise regularly? □ Yes □ No Activity: ______________ hours/week_____________

Do you follow a special diet? □ low fat □ low carb □ vegetarian □ other ________________________

How many meals/day do you have? _______________ Servings of calcium per day? _______________

Do you wear seatbelts? □ Yes □ No Do you feel safe at home at present? □ Yes □ No

Do you have smoke alarms at home? □ Yes □ No Has anyone ever physically hurt or threatened you? □ Yes □ No

Do you have guns in your home? □ Yes □ No Has anyone ever hit, kicked, or choked you? □ Yes □ No

Has anyone ever forced you to have sexual activity? □ Yes □ No

OB/GYN HISTORY: Number of Pregnancies: _______ Living: _______ Miscarriages: _______ Abortions: ______

Are you currently sexually active? □ Yes □ No Do you partner with □ Men □ Women □ Other ___________

Sexual orientation: ________________________ Gender identity: ________________________________

Do you use contraception? □ birth control pills □ contraceptive ring □ contraceptive patch □ condoms □ IUD
□ tubal ligation/vasectomy □ diaphragm □ other ____________________________

Planning a pregnancy in the next year? □Yes □ No Last Menstrual Period :__________________

Age at first period:______ Occurs every ____ days Length of flow: ____ days Age at Menopause:________

History of infections (please check all that apply): □ herpes □ gonorrhea □ chlamydia
□ syphilis □ PID □ warts □ yeast □ trichomonas □ gardnerella

Have you had an abnormal PAP in the past? □ Yes □ No

Please list any new concerns you have experienced in the past 2 weeks.

Please understand that we may need to have you schedule a follow-up visit.

Date ________________________ Signature____

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Patient Label

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ___*0*___ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Name:
DOB:
MRN:

Name: ______________________ DOB: ____________ Date: ______________

CAGE-AID QUESTIONNAIRE

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

	In the past 12 months	**Yes**	**No**
1	Have you ever felt that you ought to cut down on your drinking or drug use?		
2	Have people annoyed you by criticizing your drinking or drug use?		
3	Have you ever felt bad or guilty about your drinking or drug use?		
4	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

	Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**Over half the days**	**Nearly every day**
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
	Add the score for each column				
	Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Spitzer RL[1], Kroenke K, Williams JB, Löwe B: A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7.