Premier
Women's Health

**Problem Visit**

Name_____ Date_____

Date of Birth:_____ Age: _____ Home #:_____

Cell #:_____ Work #:_____

Address: _____

Employer: _____ Occupation: _____

Briefly list the reason for your visit today:

_____

_____

What was the first day of your last menstrual cycle? _____

How many pregnancies have you had? _____ How many deliveries have you had? _____

Have you had any new medical problems or surgeries since your last visit?

_____

_____

_____

_____

Please list your current medications including vitamins and herbal supplements:

_____

_____

Have any of your family members (blood relatives) had any new medical problems?

_____

_____

Do you smoke? YES NO If yes, how much per day? _____

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**Patient Release of Information**

The best phone number to reach you Monday through Friday, 8 AM to 5 PM is : (_ _ _)
_ _ _ - _ _ _ _.(ext. _____- if applicable).
If you cannot be reached, do we have your permission to leave a message or results with: (check all that apply)
My parent: _____ My spouse:_____ No, only me_____
Home answering machine: _____
Work, Voice Mail:_____ (_ _ _ ) _ _ _ - _ _ _ _ Ext. ____

_____

Are you currently experiencing any of the following? If yes, circle and explain.

| SYMPTOMS | No | If YES, please explain. |
|---|---|---|
| **1. Constitutional**: Weight loss, fatigue, fever | | |
| **2. Eyes:** visual changes, blurred vision | | |
| **3. Ears, nose, mouth, throat**: Hearing loss, nosebleeds | | |
| **4. Cardiovascular**: Chest pain, swelling in extremities | | |
| **5. Respiratory**: Shortness of breath, chronic cough, wheezing | | |
| **6. Gastrointestinal**: Diarrhea, Constipation, Blood in stool, nausea, vomiting | | |
| **7. Genitourinary**: Pain with urination, frequency of urination, leakage of urine | | |
| **8. Musculoskeletal**: Back pain, Neck pain | | |
| **9. Neurological:** Headaches, Numbness, Dizziness, Seizures | | |
| **10. Psychiatric:** Depression, Anxiety, Frequent Crying | | |
| **11. Endocrine**: Heart palpitations, unexplained weight gain, heat or cold intolerance | | |
| **12. Skin**: Rash, breast lumps | | |
| **13. Blood/lymph:** swollen glands, excessive bleeding | | |
| **14.Allergy/Immunology**: Allergic reaction, frequent infections | | |

I hereby authorize the office of Premier Women's Health to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. I authorize this office to use "FAX" as a means of rapid communication with other physician's offices, pharmacies, laboratories, and insurance companies that are pertinent to my care. I understand that this office follows HIPAA protocols and protects my privacy as a patient. By signing this form, I am consenting to medical treatment.
I have read and understand the above statements.

Date: _____ Signature: _____