PATIENT NAME: _____

DATE OF BIRTH: _____

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Patient Health History

Reason for today's visit?

_____

_____

Obstetrical History

Last Menstrual Period: _____/_____/_____

Total Pregnancies: _____ Total Miscarriages: _____ Total Abortions: _____

Ectopic Pregnancy: _____ Children Living: _____

Date	Sex	Weight	Type of Delivery	Complications

Gynecologic History

1. How old were you when your periods began? _____
2. Are your periods regular? Yes / No How many days in cycle? _____
3. How heavy is your bleeding? _____ How many days of bleeding? _____ 4. Do you have cramping? Mild / Moderate / Severe

[Questions 5-14 optional]

5. Are you sexually active? Yes / No 6. Do you have pain with intercourse? Yes / No
Age at first intercourse: _____ Total number of sexual partners: _____

7. Do you have any history of venereal disease such as gonorrhea, chlamydia, herpes, HPV, genital warts, or. syphilis? _____

8. History of infection in the uterus and/or fallopian tubes? _____When?_____9. __
History of sexual abuse: _____ History of physical abuse: _____ 10. Date of last Pap smear: _____ 11. Have you ever had an abnormal Pap smear? _____

12. What is your birth control method: (please circle) none, condoms, spermicidal, foam, Depo-Provera, IUD, Nexplanon, birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy, natural family planning.

Are you satisfied with this method? Yes / No 13. Do you have history of breast disease? _____ 14. Sexual Orientation: Heterosexual / Homosexual / Bisexual

Patient Name :_____ Date of Birth: _____

Personal Medical History

Please list current medications/dosage you are taking (please include supplements & over the counter medications):

_____
_____
_____
_____

Are you allergic to any medications? _____

Have you ever had any unusual childhood illnesses, such as rheumatic fever or seizures? _____
_____

Who is your primary care physician? _____

Surgical History

Please list all surgeries you have had and approximate dates:

	Surgery	Date
1.		
2.		
3.		
4.		
5.		

Hospitalizations: (other than pregnancy):

_____
_____
_____

Trauma History: Please list any broken bones, concussions, or injuries you may have had in the past:

_____
_____
_____

Immunizations:

When was your last Tetanus vaccine? _____

Have you had the HPV vaccine? Yes / No Hepatitis B vaccine? Yes / No

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PATIENT INFORMATION

Name (First, Middle, Last) _____

Date of Birth _____ Gender _____ Occupation _____

Married Single Widowed Divorced / Employed Retired Unemployed

Address _____

Home/Cell Phone _____ Work Phone _____

Email Address _____ Race _____

Emergency Contact _____ Relationship _____

Home/Cell Phone _____ Work Phone _____.

Referring Physician _____ Primary Care Physician _____

Pharmacy Name _____ Pharmacy Crossroads _____

Is the patient the financially responsible party? ____ Yes ____ No

If no, Indicate the person who is _____ Relationship _____

PRIMARY INSURANCE:

Card Holder Name _____ Relationship _____

Card Holder DOB _____

Insurance Company _____ ID# _____ Group # _____

SECONDARY INSURANCE:

Card Holder Name _____ Relationship _____

Card Holder DOB _____

Insurance Company _____ ID# _____ Group # _____

I verify that the information is correct as it is listed on my insurance plan. That I am giving permission to bill insurance for my medical care. If there are inaccuracies, then I may be responsible for the cost of my medical appointment.

_____

I do not have an insurance plan valid for the medical visit and I will be self-pay.

_____

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-ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I acknowledge I have received a copy of the Notice of Privacy Practices and that I may print it, request a print or review it electronically on PDF.

-AUTHORIZATION FOR MEDICAL CARE:

I hereby authorize Evolve Health & Wellness to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-REFERRAL WAIVER:

I acknowledge that in the course of my treatment, Evolve Health & Wellness, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Evolve Health & Wellness will notify me when such a referral occurs. Evolve Health & Wellness assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Evolve Health & Wellness make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. Evolve Health & Wellness is not responsible should my insurance process claims at the noncontracting level for the referred service(s).

-COMMUNICATION PREFERENCES:

By signing below, I give permission to the text and email to Evolve Health & Wellness, its staff and provider to communicate with me about my medical care. I understand my healthcare information is not private or secure through these means.

□ Do NOT text or email me about my medical care. Phone calls only. Email: _____ Text:_____

By signing below, I give permission to the person(s) listed to receive LIMITED information about my care. I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1.□ Do NOT share ANY information with anyone.

2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the Type(s) of information we can share with each respective individual(s).

Name: Relationship:

□ Billing Information □ Relevant Test Results & Treatment Recommendations

3. Physicians/Providers:

□ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name of Provider / Practice Name:

Signature of Patient or Personal Representative _____

Printed Name_____ Date _____

If Personal Representative, Relationship to Patient: