Total Woman Care
OBSTETRICS & GYNECOLOGY

942 Johnson Ridge Road
Elkin, NC 28621
(336)526-3500

NAME:_____ **DATE:**_____ **DOB:**_____

REFERRD BY:_____ **AGE:**_____

REASON FOR VISIT: ☐**ROUTINE PHYSICAL** ☐**PROBLEM**

DESCRIBE PROBLEM:_____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST

MAJOR ILLNESSES	YES	NO		YES	NO
Anemia	☐	☐	Hepatitis / Jaundice	☐	☐
Anxiety	☐	☐	High Blood Pressure	☐	☐
Arthritis / Joint Pain	☐	☐	High Cholesterol	☐	☐
Asthma	☐	☐	Kidney Infection	☐	☐
Blood Transfusion	☐	☐	Kidney Stones	☐	☐
Bowel Trouble	☐	☐	Mood Disorder	☐	☐
Breast Cancer	☐	☐	Pneumonia	☐	☐
Cancer	☐	☐	Rheumatic Fever	☐	☐
Chronic Lung Disease	☐	☐	Sexually Transmitted Diseases	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Tuberculosis - TB	☐	☐
Fracture	☐	☐	Thyroid Disease	☐	☐
Glaucoma	☐	☐	Ulcers	☐	☐
Heart Murmur	☐	☐	OTHER: _____		
Heart Trouble	☐	☐	_____		

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Abnormal PAP Smear	_____	Tetanus	_____
Bone Density	_____	Mammogram	_____
Colonoscopy / Sigmoidoscopy	_____	Last PAP Smear	_____
Flu Shot	_____	TB Skin Test	_____

PLEASE LIST PAST ILLNESSES, OPERATIONS, HOSPITALIZATIONS YOU HAVE HAD:

TYPE:	DATE	TYPE:	DATE
_____		_____	
_____		_____	
_____		_____	
_____		_____	

PL**EASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:**

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
_____			_____		
_____			_____		
_____			_____		
_____			_____		

ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?) PLEASE LIST

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CIRCLE AND CHECK IF ANY RELATIVES HAVE HAD & LIST THEIR RELATIONSHIP TO YOU

MAJOR ILLNESSES:	YES	NO		YES	NO
Anemia	☐	☐_____	Arthritis / Joint Pain	☐	☐_____
Asthma	☐	☐_____	Bowel Trouble / Ulcers	☐	☐_____
Breast Cancer	☐	☐_____	Cancer	☐	☐_____
BRCA Carrier	☐	☐_____	Depression / Anxiety	☐	☐_____
Chronic Lung Disease	☐	☐_____	Glaucoma	☐	☐_____
Diabetes	☐	☐_____	Hepatitis / Jaundice	☐	☐_____
Heart Trouble / Murmur	☐	☐_____	High Cholesterol	☐	☐_____
High Blood Pressure	☐	☐_____	Stroke	☐	☐_____
Kidney Infections / Stones	☐	☐_____	Tuberculosis - TB	☐	☐_____
Thyroid Disease	☐	☐_____			

YOUR GYN HISTORY

Do you use Birth Control? ☐Yes ☐ No
☐ Condoms ☐ Nuvaring ☐ Depo Provera ☐ Diaphragm ☐ Birth Control Patch
☐ Contraceptive Foam / Jelly ☐ Tubal Ligation ☐ Vasectomy ☐ Withdrawal
☐ Natural Family Plan / Rhythm ☐ IUD - KIND_____ Date Inserted: _____
☐ Birth Control Pill NAME :_____
Date of Last Period: _____ Age of first period:_____
Do you have clots: ☐ Yes ☐ No Do you have cramps: ☐ Yes ☐ No Do you have pain? ☐ Yes ☐ No
Periods are every : ____ days Lasting _____days. FLOW: ☐ Light ☐ Moderate ☐ Heavy
Number of Pads/Tampons per day:_Do you have breakthrough bleeding? ☐ Yes ☐ No
Have you gone through Menopause? ☐ Yes ☐ No Age:___
Are you on Hormone Replacement Therapy (hormones) ? ☐Yes ☐No

YOUR OB HISTORY

Total number of Pregnancies____Full Term Births____Premature:_____
Abortions Induced:_____Miscarriages_____ Living Children: _____

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

	Birth Date	Wks Gest	Labor hrs	Baby Wt	M/F	Del Type Vag or C/S	Anes	Early Labor	Wt Gain	Complications	Location
1											
2											
3											
4											
5											
6											

SOCIAL HISTORY

Do you do a Self Breast Exam? ☐ Yes ☐ No
Do you drink Milk? ☐ Yes ☐ No Glasses per day:_____
Do you take Calcium? ☐ Yes ☐ No Name and Dosage:_____
Do you Exercise? ☐ None ☐ Less the 3 times per week ☐ More than 3 times per week
New Sexual partner ☐ Yes ☐ No Lifetime Sexual partners: ☐ Less than 5 ☐ More than 5
Smoking ☐ Yes ☐ No Packs per Day:_Number of Years:_____
Alcohol ☐ Yes ☐ No Quantity: _____
Drug User ☐ Yes ☐ No Kind:_____Frequency:_____
History of Abuse ☐ Yes ☐ No ☐ Physical ☐ Emotional ☐ Sexual
List all "Natural" or herbal remedies, over the counter drugs, vitamins or minerals you are taking:_____

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PLEASE BE SURE TO COMPLETE ALL OF THIS FORM – PLEASE ASK, IF YOU HAVE ANY QUESTIONS

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Work Phone#: _____ Cell Phone:_____

Date of Birth: _____ Social Security#:_____

Emergency Contact- Spouse/Other-Name: _____ Contact#: _____

Email Address:_____

SPOUSE INFORMATION Spouse Employer: _____ Employer Phone#:_____

Social Security#: _____ Date of Birth: _____ Cell Phone#:_____

Referred/Recommended By:_____

Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow [ ]

Race: _____ Student: No [ ] Yes [ ] If yes, are you a: Part-time [ ] Full-time [ ]

Employer: _____ Part-time [ ] Full-time [ ]

Work Phone#: _____ Extension#: _____

What shift do you work? Day [ ] Evening [ ] Night [ ]

Who is your family doctor? Name: _____

Preferred Pharmacy: _____ Location:_____

INSURANCE INFORMATION: PLEASE PRESENT YOUR CARDS TO THE RECEPTIONIST – WE WILL COPY THEM FOR OUR FILES. Please provide us with **ALL** of your insurance cards. If you **DO NOT** have your cards with you today, you may be asked to reschedule to another date. **It is our office policy that you pay your insurance co-payment at the time of your scheduled visit.**

My signature below indicates that I authorize ***TOTAL WOMAN CARE, LLC*** to file any/all claims for medical care provided to me by the providers in this practice. I understand that insurance will be filed first, but if or when insurance does not pay all of the charges, I will be responsible for the remaining balance. If you have any questions, feel free to ask office staff.

_____(SEAL) _____
Patient Signature/Parent or Guardian Date Signed

Thank you for choosing Total Woman Care for your Obstetric and Gynecologic Needs!
We look forward to taking care of you!

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NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed. It further details how you can get access to this information. PLEASE review it carefully. This notice is provided in two pieces. The tri-fold brochure summarizes how we will handle your health information. This notice provides you with details regarding our privacy polices and procedures.

How we may use and disclose you health information. We use your health information for treatment, to get reimbursed for treatment, for administrative reasons, and to assess the quality of care that you receive. Examples of how we may use your health information are: sharing treatment history with a provider to whom you are being referred; documenting procedures performed to insurance carriers for payment, etc. Information may be disclosed via paper, electronic mail, fax, or other means. If you sign an authorization to release your information now, you can change your decision at a later date by notifying us in writing.

Your Rights. You have the right to review and obtain copies of your health information that we use to make decisions regarding your health. Furthermore, you have the right to request a list of particular types of disclosures that we have made with your health information. If you think we have incorrect or incomplete health information on you, you should request that we correct our current information and add any information you desire.

Our Legal Duty. We are required under that Health Information Portability and Accountability Act (HIPAA) to protect your health information and provider you this notice about our privacy procedures. We must follow the procedures that are described in our notices and request your acknowledgement of receipt of this notice. Please be aware that we may change our procedures from time to time. If we make a major change in our privacy procedures, a new notice will be posted near our check in area for your viewing. You are welcome to request a copy of the correct privacy policy and procedures at anytime. For detailed information regarding our privacy policy, please contact Practice Manager, Total Woman Care, LLC, 942 Johnson Ridge Road, Elkin, NC 28321, 336-526-3500.

Privacy Complaints. If you feel that we have violated your privacy rights, our privacy polices & procedures, or you disagree with a decision regarding accessing your health information, please contact the Practice Manager. You may also send a written complaint to the U.S. Dept of Health and Human Services. The Practice Manager can provide you with the address upon your request.

Acknowledgement of receipt of Privacy Procedures. Please print you name, sign, and date below to acknowledge that you have received the "Notice of Privacy Polices and Procedures of Total Woman Care, LLC." Please return this acknowledgement to the receptionist.

Name (Please Print): _____

Signature: _____

Date: _____

Total Woman Care
OBSTETRICS & GYNECOLOGY

Name :_____ DOB:_____Date:_____

REVIEW OF SYSTEMS
PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW

CONSTITUTIONAL
Weight Loss ☐
Weight Gain ☐
Loss of Appetite ☐
Fever ☐
Chills ☐
Fatigue ☐
Night Sweats ☐

EYES
Vision Changes ☐
Eye Pain ☐

H.E.N.T.
Headaches ☐
Dizziness ☐
Lightheadedness ☐
Sore Throat ☐
Sinus Pain ☐
Nasal Congestion ☐
Nasal Discharge ☐

BREAST
Lumps ☐
Nipple Discharge ☐

RESPIRATORY
Cough ☐
Shortness of Breath ☐
Wheezing ☐

NEUROLOGICAL
Tingling or Numbness ☐
Seizures ☐

MUSCULOSKELETAL
Joint Pain ☐
Back Pain ☐
Muscle Weakness ☐

ALLERGIC/IMMUNOLOGIC
Seasonal Allergies ☐
Frequent Illness ☐

NOTES

GASTROINTESTINAL
Nausea ☐
Vomiting ☐
Diarrhea ☐
Constipation ☐
Heartburn ☐
Abdominal Pain ☐
Hemorrhoids ☐
Blood in Stool ☐

SKIN
Rashes ☐
Itching ☐
Color Changes ☐
Hair Growth Changes ☐

GENITOURNARY
Irregular Period ☐
Painful Period ☐
Significant PMS ☐
Vaginal Discharge ☐
Painful Intercourse ☐
Genital Sores ☐
Urgency of Urination ☐
Frequency of Urination ☐
Pain with Urination ☐
Leakage of Urination ☐
Difficult Voiding ☐
Blood in Urine ☐
Decreased Sex Drive ☐

PSYCHIATRIC
Depression ☐
Anxiety ☐
Suicidal Thoughts ☐
Homicidal Thoughts ☐
Difficulty Sleeping ☐

HEMATOLOGIC/LYMPHATIC
Easy Bleeding ☐
Easy Bruising ☐
Enlarged Lymph Nodes ☐

CARDIOVASCULAR
Irregular Heartbeats ☐
Rapid Heart Rate ☐

NOTES

REVIEWED BY:_____