

Please complete all information up to solid line

Allergies: _____ **Pharmacy Name/ Number:** _____

Can we leave a message? Yes No

1. Vaginal infection or pelvic pain 2. Screening for STI's 3. Bladder infection 4. Breast check
5. Pap Smear 6. Post-abortion care/concerns 7. Birth Control 8. Other: _____

List any current medications (over-the-counter or prescription) or herbs: _____

UA: (L/N/P/G) ____/____/____/____ Other: _____

Comments: _____ Initials: _____

	(WNL)	(Other/Deferred)	Description/Diagram
Thyroid:	()	()	
Lungs:	()	()	
Heart:	()	()	
Breast:	()	()	
Abdomen:	()	()	
Skin:	()	()	
Vulva:	()	()	
Vagina:	()	()	
Cervix:	()	()	
Uterus:	()	()	
Adnexa:	()	()	
Rectal:	()	()	
Discharge:	()	()	
Other:	()	()	
Pap: Yes/No	Cultures: Yes/No	GC/ Chlamydia/ Herpes/ Other:	

Wet Prep: Yes/No WNL Yeast; Clue; Whiff; Trich; WBC's: #___/hpf
Assessment: Plan:

RNC/CNM/MD: _____

FEMINIST _____ Date: _____ Time: _____

If LARC or Bx, time out performed ☐

**FEMINIST WOMEN'S HEALTH CENTER
MEDICAL HISTORY**

Date ____/____/____

Legal Name _____ Preferred Pronoun (he/she/ze) _____
Preferred Name _____ DOB ____/____/____ Age _____
Address _____ Apt # _____ Phone (h) (____) ____-____
City _____ Within City Limits: Yes () No () (w) (____) ____-____
County _____ State _____ Zip _____ (c) (____) ____-____
At what phone # may we contact you? _____ May we leave a message: Yes () No ()
Emergency contact: Name _____
Address _____ Apt # _____ Phone (h) (____) ____-____
City _____ State _____ Zip _____ (w) (____) ____-____
Years of Education: _____ Language you speak: English, Spanish, French, Other _____
Can you read/understand English to fill out this form: Yes () No ()
If not English speaking, Interpreter's name _____
Pharmacy # _____ Religion _____
DRUG ALLERGIES: _____ FOOD ALLERGIES: _____
CURRENT MEDICATIONS: _____

Please circle Y for yes or N for no, or fill in the space for the following questions:

Contraceptive History (Birth Control):

1. Y N Do you need/want birth control method/information.
2. Current method of birth control used: _____
3. How long using this method; _____ Problems: Y N
Describe: _____
4. When, if ever, would you like to be pregnant? _____
5. What method do you want to use now? _____
Methods used in past: (circle): Pills / Patch / Ring / Shot / Implant / IUD / Condoms /
Cervical cap / Diaphragm / Foam / Gel / Sponge / Abstinence / Withdrawal /
Sterilization / Tubes tied / Vasectomy / Rhythm / Natural Family Planning /
Emergency Contraception / Other _____

Sexual History/ Information: this information helps us with your care:

7. Age of first sexual experience _____ Currently in sexual relationship: Y N
Partner(s): men / women / both now () always ()
Do you have more than one partner? Y N
partners in last year: _____
Do you practice safe sex Y N vaginal / oral / anal sex
Partner's History (circle all that apply):
Has other partners/ has same sex partners/ is a hemophiliac/ is HIV+/ has AIDS/
uses recreational drugs

Social History:

Circle Y for yes or N for no to the following indicating your recent experience:

8. Y N Has anyone forced you to have sex
9. Y N As a child did anyone touch your private body parts or ask you to touch theirs?
10. Y N Are you afraid of your partner/family member
11. Y N Do you feel you are in an abusive relationship?
12. Y N Emotional/mental illness? Anti-Depressive, anxiety or psychotic medications?
13. Y N Do you smoke? How many cigarettes/day _____
14. Y N Do you drink? How much alcohol do you drink per week _____
15. Y N Do you use recreational drugs? What kind? _____ Date of last use _____

Comments - Staff Only

OB History:

Complete below:

16. Total No. Pregnancies including current: _____ Living children: _____
Live births: _____ Miscarriages: _____ Abortions: _____
Ectopic/tubal: _____ Other: _____
of C-sections: _____ Last pregnancy when: _____
Problems with pregnancies: (high blood pressure, seizures, toxemia, gestational diabetes, birth defects) other: _____

17. Are you Rh neg: Y N Have you received Rhogam: Y N

18. Y N Trouble getting pregnant/staying pregnant

Personal Medical History:

Circle Y for yes or N for no to the following and circle items that apply: (Current & Past)

19. Y N Eye/vision problems, glasses/contacts
20. Y N Deaf/Mute. Do you know sign language Yes No
21. Y N Heart problems/palpitations/murmurs/surgery/MVP (Mitral Valve Prolapse)
22. Y N High Blood Pressure
23. Y N Strokes/Blood Clots in head, heart, brain/Head injury
24. Y N Varicose veins
25. Y N High cholesterol/ blood fats
26. Y N Diabetes/High Sugar: (insulin/diet /oral/) Only with pregnancy
27. Y N Bladder/Kidney problems/infections
28. Y N Headaches/migraine, stress related or other
29. Y N Seizures/epilepsy: Date of last seizure _____
30. Y N Thyroid conditions/ medications
31. Y N Liver disease/Hepatitis
32. Y N Stomach problems/gastritis/ ulcers/reflux disease
33. Y N Bowel problems/Colitis/Irritable bowel/Crohns
34. Y N Lung Problems/Disease/Asthma=(circle one) Childhood, Seasonal; Chronic
35. Y N Anemia/Low Iron/Sickle Cell/Thalassemias/Blood diseases/Lupus
36. Y N Gallbladder disease/Surgery
37. Y N Cancer
38. Y N Numbness in legs or arms
39. Y N Are you currently under care for a problem/illness by a health care professional? Explain _____
40. Y N Have you ever been hospitalized (except childbirth):
Explain _____
41. Y N Received blood products before 1978
42. Y N Do you faint with needles/finger sticks/pap smears
43. Y N Ever react to ANY DRUG/MEDICATION/FOOD: including (circle):
barbiturates, anesthesia, shellfish, eggs, soy, Iodine, metals, latex _____
44. Y N Have you ever been put to sleep for any surgery? Did you have any problems-Y N
45. Y N Immunizations up to date:
Rubella vaccination: Y N Hepatitis B: Y N HPV Vaccine: Y N
46. Y N Do you have any piercings/removable devices in your mouth?
47. Y N Do you use herbs/vitamins/complimentary therapies

Comments – Staff Only

GYN History:**Comments - Staff Only**

Circle Y for yes or N for no to the following:

48. Y N Have you ever had a pelvic exam/ Pap smear? Date of last exam _____
49. Y N Breast disease or surgery
50. Y N Breast/nipple discharge/leaking
51. Y N Are you breast feeding/nursing
52. Y N Mammogram
53. Y N Vaginal infections/itching /burning
54. Y N Vaginal pain/bumps/swelling/sores
55. Y N Sexually transmitted infections (circle all that apply):
Herpes, HPV, Chlamydia, Gonorrhea, Trichomonas, Syphilis,
HIV, Hepatitis B, Group B Streptococcal Infection
56. Y N Pelvic inflammatory disease (PID) Date _____
Treatment: _____
57. Y N Endometriosis/Uterine fibroids
58. Y N Cysts on ovaries
59. Y N Abnormal Pap (date) _____
Treatment: Repeat pap (date) _____
Colpo/Cryo/LEEP/Laser
60. Y N Genital circumcision
61. Y N Bleeding and/or pain with sex

Menstrual History:

62. Age period began _____
Are your cycles/periods regular? Yes () No () Sometimes ()
days in each cycle: _____ # days you bleed: _____
Use pads / tampons / other _____ # used on heaviest day(s) _____
63. Y N Cramps/pain/bloating/depression
64. Y N Do you use medications/herbs/other _____ for relief
65. Y N Bleed between periods
66. First day of last period ____/____/____ Normal () Abnormal ()

Family History:**Adopted: Y N**

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles

67. Y N Diabetes _____
68. Y N Heart attack before age 50 _____
69. Y N High Blood Pressure _____
70. Y N Cancer (breast, ovarian, uterus) _____
71. Y N High cholesterol _____
72. Y N Alcoholism/addictions/mental illness _____
73. Y N Problems with General Anesthesia _____
74. Y N Birth defects/genetic illness _____

- What else would you like us to know about you? _____
- I affirm that I have been counseled about available options for birth control, including the benefits and risks of the method I have chosen: _____ (method(s))
- I affirm that all of the medical information stated above is true.

Client signature _____ Date: _____ Updated: _____

Counselor signature _____ Date: _____ Updated: _____

RN Pre-op Signature _____ Date: _____ Updated: _____

MD/NP Review _____ Date: _____ Time: _____ Updated: _____ Time: _____

APN/CRNA Review _____ Date: _____ Time: _____ Updated: _____ Time: _____

FEMINIST WOMEN'S HEALTH CENTER

CONSENT FOR WELLNESS SERVICES

Please read and sign below if you have an appointment with the nurse practitioner today:

I consent to care and treatment at the Feminist Women's Health Center. I understand that I will be seen by a nurse practitioner. I also understand that all or part of my accessory health services will be provided by trained healthworkers.

If the nurse practitioner finds anything beyond the scope of her practice and/or experience during my examination, I understand that I may be referred to a physician or other facility. I understand that the nurse practitioner may consult with a collaborating physician by telephone. I understand that if my situation warrants a referral to another health care provider, I shall be solely responsible for making those arrangements and for any fees associated with the healthcare I receive.

Client Signature

Date

Staff Signature

Date

CONSENT FOR LABORATORY SERVICES

I consent to laboratory testing at the Feminist Women's Health Center. I understand that the interpretation of any laboratory test results should be made only by a licensed health care provider as factors unclear to the lay person may exist.

Because the implications of laboratory testing results can be complex, involving medical, emotional, and social issues, some results will only be reported to the client in person and so will require a follow up visit. My laboratory test results and patient information are confidential and may only be released to me. I will need to sign a request for release of medical records if I want my results mailed or faxed to another health care provider.

Client Signature

Date

Staff Signature

Date

**Feminist Women's Health
Center
Patient Privacy Notice
Authorization**

In order to comply with new federal guidelines outlined in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), a Federal law which seeks to protect the privacy of consumers' healthcare information, we are advising you of your right as to how your medical information may be used.

The *NOTICE OF PRIVACY PRACTICES* located in the waiting rooms of the clinic outlines how personal information about you may be used and how you can get access to this information. If you would like a paper copy of the *NOTICE OF PRIVACY PRACTICES* please ask and we will be glad to provide you with one.

In accordance with the HIPAA Privacy Rule 45 CFR164.506 if you use a credit card to pay for services at Feminist Women's Health Center and subsequently dispute those charges with your banking institution/credit card holder, FWHC has the right to release some portions of your medical record should a financial dispute occur. By signing this form I certify that I fully understand this Privacy Notice and the rights of both myself and the FWHC.

I authorize the Feminist Women's Health Center to communicate medical information pertaining to my care by the methods outlined in the *NOTICE OF PRIVACY PRACTICES*. I am aware that I may ask for a paper copy of the *NOTICE OF PRIVACY PRACTICES* at any time.

Client signature_____

Witness_____

Feminist Women's Health Center

Request for Information

We are an inclusive organization that serves people of all identities, across age, ethnicity, race, nationality, gender and sexual orientation. We are interested in learning about the identities that you hold and the ways in which they affect how you experience the world.

The following questions are optional, please share as much as you are comfortable:

1. Please indicate your race:

- | | |
|---|---|
| <input type="checkbox"/> Asian/South Asian/Central Asian | <input type="checkbox"/> Multiracial |
| <input type="checkbox"/> Black and/or African-American | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Native American or Alaska Native | <input type="checkbox"/> Prefer to self-describe: _____ |
| <input type="checkbox"/> Hispanic, Latinx or Spanish origin | |

2. Please indicate your current school or highest degree obtained:

- | | |
|---|---|
| <input type="checkbox"/> Less than high school diploma | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> High School Degree or Equivalent (GED) | <input type="checkbox"/> Post Graduate Degree |
| <input type="checkbox"/> Associate Degree | |

3. Please indicate your relationship status:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Legally Separated |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Partnered | <input type="checkbox"/> Widowed |

4. Please indicate how you heard about Feminist Women's Health Center:

- ☐ Been here before
- ☐ Friend/Word of Mouth
- ☐ Feminist Center event
- ☐ Health Fair
- ☐ Internet/Google Search
- ☐ National Abortion Federation (NAF) hotline
- ☐ Planned Parenthood
- ☐ ARC Southeast
- ☐ Physician/Referral: _____
- ☐ Other: _____

4. Sexual Orientation - Please select all identities that describe you:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Asexual | <input type="checkbox"/> Queer |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Gay |
| <input type="checkbox"/> Questioning | <input type="checkbox"/> Straight/Heterosexual |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Pansexual | <input type="checkbox"/> Prefer to self-describe: _____ |

4. Gender Identity – Please select all the identities that describe you:

- ☐ Woman
- ☐ Man
- ☐ Two-Spirit
- ☐ Intersex
- ☐ Trans Man/ Man of Trans experience
- ☐ Trans Woman/ Woman of Trans experience
- ☐ Prefer not to answer
- ☐ Prefer to self-describe_____

7. Please indicate the combined annual income level for your entire household:

- | | | |
|---|---|--|
| <input type="checkbox"/> Less than \$20,000 | <input type="checkbox"/> \$35,000 to \$49,999 | <input type="checkbox"/> \$75,000 - \$99,999 |
| <input type="checkbox"/> \$20,000 to \$34,999 | <input type="checkbox"/> \$50,000 - \$74,999 | <input type="checkbox"/> Over \$100,000 |

9. Please indicate the number of family members in your household, including yourself:

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ More than 5