FEMINIST WOMEN'S HEALTH CENTER

Please complete all information up to solid line

Today's Date: ___/___/_____Name: _____ **DOB**: ___/___/_____**Age**: _____

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

***Lab results**: You will only be notified if your results are abnormal. Results are reported in 5 – 7 business days. Please provide the address where results can be mailed: _____If you prefer to be called, provide your phone number here: _____.

Can we leave a message? Yes No

Purpose of Visit: ***(Please circle ALL that apply:)***

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:_____

The following information will help us make decisions about your care today:

First day of **last normal** period: _____ Last date of sexual intercourse: _____

Current method/s of birth control (including condoms): _____

How long have you used your current method of birth control? _____

Please list any problems you are having with your birth control method: _____

Do you use birth control every time you have intercourse? Circle one: Yes No N/A

Current method/s of protection against sexually transmitted infections: _____

Do you use protection every time you have intercourse? Circle one: Yes No N/A

If applicable: number of sexual partners: _____Partners are: Male Female Both

Do any of your partners have a sexually transmitted infection?: Yes No N/A

Length of time with current partner: _____months/years N/A

Are you currently breastfeeding? Yes No

Have there been any changes in your medical history since your last visit? Yes No

Explain:_____

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

OFFICE USE ONLY

Lab: as applicable: *Temp:*_____*Resp*:_____*B/P*:____/____*Pulse*:_____*HCT*:_____Ht:_____Wt:_____

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

Pregnancy slide test: POS(+)/ NEG(-) *Test pack*: POS(+)/ NEG(-)

HSV I: Client would like to receive positive test results? Yes ☐No ☐

Comments:_____ **Initials**:_____

EXAMINATION:

	(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 _____

Comments - Staff Only

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_____

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: _____

Updated 11/06/2014

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 heath 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:

- ☐ Asian/South Asian/Central Asian
- ☐ Black and/or African-American
- ☐ Middle Eastern or North African
- ☐ Native American or Alaska Native
- ☐ Hispanic, Latinx or Spanish origin
- ☐ Multiracial
- ☐ White/Caucasian
- ☐ Prefer not to answer
- ☐ Prefer to self-describe: _____

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

- ☐ Less than high school diploma
- ☐ High School Degree or Equivalent (GED)
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Post Graduate Degree

3. Please indicate your relationship status:

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Legally Separated
- ☐ Divorced
- ☐ 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:

- ☐ Asexual
- ☐ Lesbian
- ☐ Questioning
- ☐ Bisexual
- ☐ Pansexual
- ☐ Queer
- ☐ Gay
- ☐ Straight/Heterosexual
- ☐ Prefer not to answer
- ☐ 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:

- ☐ Less than $20,000
- ☐ $20,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 - $74,999
- ☐ $75,000 - $99,999
- ☐ Over $100,000

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

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