Patient Information

Last Name:____________________________________First Name:___________________________________

Preferred Name:________________________________Middle:_______________________

Former Last Name:_____________________Date of Birth:________________SSN:______________________

Address:____

____

Contact Information

Home Phone: ______________________ _______I give you permission to call me at home.
_______You may leave a detailed message here.

Work Phone:_______________________ _______I give you permission to call me at work.
_______You may leave a detailed message here.

Mobile Phone:______________________ _______I give you permission to call my cell phone.
_______You may leave a detailed message here.

_______You may **email** me at:____(email is required for use of patient portal)

Sharing of Medical Information

____I do not wish to share my medical records with anyone at this time.

____Person(s) authorized to discuss my medical information (please check billing, clinical or both):

Name:______________________________ Relationship:____________________________Billing____Clinical

Name:______________________________ Relationship: ___________________________Billing____Clinical

Name:______________________________ Relationship:____________________________Billing____Clinical

I understand that the medical provider to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements or my home (or primary) address will be used. I further understand that in some emergency situations my protected health information may be released.

Patient (guardian) Signature: ____ Date: ________________________

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Marital Status: Married Single Divorced Separated Widowed Domestic Partner

Language:______________________Race:_____________________Ethnicity:____________________

How did you hear about us? Please specify source:____

Preferred Pharmacy: ____

Preferred Radiology Facility:____

Privacy and Billing

Guardian

Last Name:____________________________________First Name:_____________________________

Middle Name:_________________________________Suffix:__________________

Emergency Contact

Name:____Relationship:__________________________

Home Phone:_____________________________ Mobile Phone:____________________________

Employment

Employer Name:_______________________________________Phone:_________________________

Usual Occupation (current or most recent):____

Usual Industry:____

Insurance Guarantor Information If your insurance is in a name other than self, please complete the following:

Patient's relationship to guarantor:

Guarantor Last Name:______________________________First Name:__________________________

Middle Name:_______________________Suffix :______________Date of Birth:__________________

Address:____

Center for Women's Health
SALISBURY
Healthcare Every Woman Deserves

Medical History: Name:_________________________________

Current Medical Problems or Conditions(Conditions for which you are currently being treated):

Problem or Condition	Laterality	Status	Date of Onset
	Rt Lt Both	Chronic Acute	
	Rt Lt Both	Chronic Acute	
	Rt Lt Both	Chronic Acute	

Patient Care Team

Primary Care Physician:____

Specialist (please state field of practice):____

Allergies No Known Allergies

Drug/Allergan	Reaction	Severity	Date of Onset
		Mild Moderate Severe Fatal	
		Mild Moderate Severe Fatal	
		Mild Moderate Severe Fatal	
		Mild Moderate Severe Fatal	

Family History No Known Family History (Immediate family: Mother, Father, Sister, Brother, Grandparent, Aunt, Uncle)

Relation (maternal or paternal)	Problem	Onset Age	Died of Age

Surgical History No prior surgeries

Procedure	Date
Has your uterus been removed? Yes No	
Has an ovary(ovaries) been removed? RT LT	

Procedure	Date

Gynecological History

Abnormal Pap: ☐ **Yes** ☐ **No** **If yes, please explain:** ____

Ever diagnosed with a STI or STD? ☐**Yes** ☐**No** **If yes, please explain:** ______________________________

Ever had a colposcopy? ☐**Yes** ☐ **No** **If yes, please explain:** ____________________________________

Age at first period: __________ **Age at first child:** ________

Date of last mammogram: ________________ **Location:**_______________________________________

Date of last colonoscopy: ________________ **Location:** _______________________________________

Date of last Pap Smear: __________________ **Location:** _______________________________________

Date of last Bone Density Study: _____________ **Location:** _______________________________________

Date of last period: ___________________ **Duration of flow:**_______________**days**

Flow is: ☐**Light** ☐**Moderate** ☐**Heavy** **Frequency of Cycle: every**___________**days**

Current Birth Control Method : ____________________ **Desired Birth Control Method :** ____________________

Sexual Problems: ☐ **Yes** ☐ **No**

Hormone Replacement Therapy: ☐ **Yes** ☐**No**

If Post Menopausal, Age at Menopause:____________ **Post Menopausal Bleeding:** ☐ **Yes** ☐ **No**