Durham Women's Clinic

Date: _____

Email: _____

Name: _____
(Last, First, Middle, Preferred Name, Preferred Pronouns)

Address:_____
(Number, Street, Apt/Unit #, City, State, & Zip Code)

Home Phone: (__)_____ **Cell**: (__)_____ **Work**: (__)_____

Preferred method of contact: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email ☐Portal

Social Security #: _____ **Date of Birth:** _____

Referred by: ☐Google ☐Facebook ☐Instagram ☐Magazine ☐Insurance ☐Friend ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
☐Domestic Partnered

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino

Race: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaska Native
☐More than one

Language: ☐English ☐Español ☐Other: _____

Employer: _____

Pharmacy: _____

Imaging Facility: _____

Primary Care Provider: _____

Emergency Contact: _____
Please list the name, number and relationship to emergency contact.

I hereby verify that the information I have provided above is correct to the best of my knowledge.

Signature: _____ Date: _____
Patient's Signature (Parents please sign if patient is a minor)

Durham WOMEN'S CLINIC

Durham Women's Clinic

Consent to call/text/email

I hereby consent to receive autodialed and/or pre-recorded ☐**calls** ☐**text messages** and/or ☐ **emails** from or on behalf of Durham Women's Clinic, a Division of UWH of North Carolina, PLLC at the telephone number provided on my account, including my wireless number, (e.g. Appointment Reminders, Lab Results Notifications, Inclement Weather Closings, etc.)

Patient Acknowledgment and Consent

I have received Durham Women's Clinic, a Division of UWH of North Carolina's Notice of Privacy Practices. This Notice was effective on January 1st, 2019.

Signature: _____ Date: _____

I allow the following person(s) to have access to my records including billing, appointments, and medical records/documentation. If you do not give access to any person(s) please leave the following section blank.

Name of person(s) and relationship to patient:

1. **_____ 2. _____**

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including these prescribed by other providers. I give my consent to my providers to this protected health information.

Signature: _____ Date: _____

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, healthcare operations, and billing and processing of insurance for benefits for which I am entitled. I will not hold my physician or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that I am responsible for all medical expenses incurred through Durham Women's Clinic, a Division of UWH of North Carolina, to release health insurance companies such information needed to process my claim with the health insurance agency. Any other release of information from my records will necessitate a specific authorization by me.

Signature: _____ Date: _____

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Today's Date: _____ Preferred Name/Pronoun: _____
What is the reason for your visit today? _____
Are you being referred to our clinic? ☐Yes ☐No
Referring Provider: _____ Primary Care Provider: _____

Medication Allergies/Reactions:

_____ _____
_____ _____

Medications, Vitamins, Herbs and Supplements
List all current medications (dose and frequency):
1._____ 2._____
3._____ 4._____
Contraceptive use (birth control) _____

List vaccine/immunizations & dates given as known:
Tetanus shot/TDaP ☐Yes Date: _____ ☐No ☐Uncertain
Hepatitis B ☐Yes Date: _____, _____, _____ ☐No ☐Uncertain
Chickenpox ☐Yes Date: _____ ☐No ☐Uncertain ☐I have had
COVID-19 ☐Yes Date: _____, _____ ☐No chickenpox

Past Medical History
Check the conditions that apply to you, personally:
☐Allergies ☐Anemia ☐Asthma ☐Blood clot/DVT ☐Breast disease ☐Diabetes ☐Eating disorder ☐Emotional problems ☐Endometriosis ☐Fibroids of uterus ☐Fibromyalgia ☐Heart disease ☐High blood pressure ☐High cholesterol ☐Irritable bowel syndrome ☐Kidney stones ☐Migraine ☐Osteoporosis ☐PCOS ☐Recreational drug use ☐Reflux ☐frequent UTI ☐Thyroid problems ☐prolonged bleeding with trauma or surgery ☐Cancer Type: _____

Past Gynecologic History
Date of your most recent period: _____ Any changes in your menstrual cycle?: _____
Date of your last mammogram: _____ ☐Normal ☐Abnormal
Date of your last Colonoscopy:_____ Results: ☐Normal ☐Abnormal
Date of your last bone density: _____ Results: ☐Normal ☐Osteopenia ☐Osteoporosis
Date of your last pap smear: _____ ☐Normal ☐Abnormal
HPV (Gardasil) ☐Yes Date: _____, _____, _____ ☐No ☐Uncertain
History of an abnormal pap smear? ☐Yes ☐No
Are you currently sexually active? ☐Yes ☐No
Sexual Orientation/Gender Identity: _____
Have you ever been diagnosed with a sexually transmitted infection? ☐Yes ☐No
If yes, please explain_____
Do you use anything to prevent pregnancy? ☐Yes ☐No
If yes, what method(s) do you use? _____
Do you want to be screened for sexually transmitted infections today? ☐Yes ☐No

Do you experience pain or other problems with sex? ☐Yes ☐No

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If yes, please explain_____
How many days does your menstrual cycle last?: _____ Do you bleed between your periods?_____

Past Pregnancy History

Total number of pregnancies _____ Full term _____ Preterm _____ Living children: _____
Miscarriages, ectopic, or abortions: _____ Adopted children: _____

1. DOB _____ Child's Gender _____ Child's Weight _____ C-Section _____ Vaginal _____
2. DOB _____ Child's Gender _____ Child's Weight _____ C-Section _____ Vaginal _____
3. DOB _____ Child's Gender _____ Child's Weight _____ C-Section _____ Vaginal _____
4. DOB _____ Child's Gender _____ Child's Weight _____ C-Section _____ Vaginal _____

Family History ☐ Adopted **Please check all that apply**

	mother	father	sibling	children	mgm*	mgf*	pgm*	pgf*	other
Hypertension									
Diabetes									
Cholesterol									
Heart disease									
Stroke									
Breast cancer									
Ovarian cancer									
Colon cancer									
Osteoporosis									
Mental illness									
Substance abuse									
Dementia									
Thyroid problems									
Clotting disorder									
Genetic disorder									
Good health									
Other									

*mgm = maternal grandmother, mgf=maternal grandfather, pgm= paternal grandmother, pgf=paternal grandfather; other would refer to biologically related aunts, uncles or cousins

Social History

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Do you use tobacco, vape, or use e-cigarettes? ☐Yes ☐No If yes, how much or how often? _____
Do you exercise? ☐Yes ☐No If yes, how often and describe _____
Do you consume caffeine? ☐Yes ☐No If yes, how much or how often? _____
Do you drink alcoholic beverages including beer or wine? ☐Yes ☐No
If yes, how many drinks per week on average? _____
Do you use drugs recreationally? ☐Yes ☐No If yes, how much or how often? _____
Do you use marijuana in any capacity? ☐Yes ☐No If yes, how much or how often? _____
What is your ethnic background: _____
What is your occupation or are you a student? _____
Are there any risks at work or school that you would like to discuss? ☐Yes ☐No
What is your relationship status? (Circle one below)
Single Married Domestic Partner Separated Divorced Widowed
Do you feel safe in your current relationship? ☐Yes ☐No
If no, please explain_____
Have you ever been emotionally, physically or sexually abused, threatened, or hurt by anyone?
☐Yes ☐No If yes, please explain_____
Do you wear your seatbelt? ☐Yes ☐No ☐Sometimes

Surgical History

List any surgeries you have had and the approximate date:
☐Appendectomy _____ ☐Gallbladder _____ ☐Tubal Ligation _____
☐Breast Surgeries _____ ☐C-section _____ ☐D&C_____
☐Endometrial Ablation _____ ☐Hysterectomy _____
☐ Other Laparoscopic Surgery _____ Ovaries Removed? ☐Yes ☐No
☐ Abdominal Surgeries _____ ☐Others _____

Have you had a blood transfusion? ☐Yes ☐No
If yes, when? _____