Full Name: _____ **DOB**: _____ **SS#** _____ **Age:** _____

Preferred Pronouns: _____ **Marital Status:** _____ **Legal Sex:** Male / Female

Sex assigned at birth: Male / Female / Decline to Report **Preferred Language**:_____ **Do you need an interpreter?** Yes / No

Address: _____**City**:_____ **State:** _____ **Zip code:** _____

Primary Phone: _____ **Cell:** _____ **Email:** _____

Preferred method of contact: MyChart / Phone / Email / Text Message / Mail **PCP:** _____

Race (select all that apply): Asian / Black or African American / White or Caucasian / American Indian or Alaska Native / Native Hawaiian or Other Pacific Islander / Other / Unknown / Decline to report

Ethnicity (select one): Non-Hispanic / Hispanic
Unknown / Decline to report

Gender Identity: Male / Female / Transgender Female
Transgender Male / Other / Decline to Report

Sexual Orientation: Straight / Lesbian or Gay / Bisexual / Something else / Decline to Report **Religion**: _____

Employment: Full-time / Part-time / Unemployed / Retired / Student / Homemaker / Decline to report

Highest level of schooling you have received: Not a high school graduate / GED / High school graduate / Some college
Associates Degree / Bachelor's Degree / Master's Degree / Doctorate or Professional Degree / Decline to report

Employer: _____ **Work phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE FOR THE PATIENT)

Name: _____ **Relationship**: _____ **DOB**: _____
SS#: _____ **Phone**: _____
Address: _____**City**:_____ **State**: _____ **Zip code**: _____
Employer: _____ **Work phone**: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ **Member ID:** _____ **Group No.:** _____
Subscriber's Name: _____ **Relationship to the patient:** _____**Subscriber DOB:** _____
Secondary Insurance Carrier: _____ **Member ID:** _____**Group No.:** _____
Subscriber's Name: _____ **Relationship to the patient:** _____**Subscriber DOB:** _____

I give permission to BHWC to speak with the following individuals regarding my medical records (Lab results, insurance, appointments) if I am not available.

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

I certify that all of the above information is correct for billing purposes and it is my responsibility to notify BHWC of any changes to my information.

Patient Signature: _____ **Date:** _____

Full Name: _____ **DOB**: _____ **Last Menstrual Period: _____**

Reason for Today's Visit (please circle)

Yearly Exam	Birth Control	Pelvic Pain	Abnormal Bleeding/Cycles STD Check
Pregnancy	Vaginal Discharge	Painful Sex	Abnormal Pap smear
Infertility	Bladder Issues	Ovarian Cyst	Other: _____

Current Medication Allergies: _____

Current Medications: _____

_____

Pharmacy: _____

Obstetrical History: ☐ **Never been pregnant** **Total number of pregnancies: _____**

Please list all pregnancies and outcome below **(include deliveries, miscarriages, abortions and fetal deaths)**

Month/YR	Gestational Age (Wks)	Birth Weight	Male/ Female	C-section/ Vaginal Del	City/State	Complications

Gynecology History:

Age of first menstrual cycle: ____ How many days do your periods last? _____ What is your period pattern? Regular / Irregular

How heavy is your flow? Light / Moderate Heavy Period Symptoms (Circle all that apply): Cramping / Bloating / Nausea / Diarrhea

Do you wear pads/tampons? _____ How often do you change them? _____ Headaches / Throbbing

Age of Menopause (if applicable): _____ **Date of Last Pap smear: _____ Date of Last Mammogram: _____**

Have you ever had an abnormal Pap smear? Yes No Date: _____

Have you ever had an abnormal Mammogram? Yes No Date: _____

Have you ever had a Leep? Yes No Date: _____

Have you ever had a colposcopy? Yes No Date: _____

Have you ever had an endometrial biopsy? Yes No Date: _____

Have you ever had a Dexa Bone Density Scan? Yes No Date: _____

Sexual History:

Age of onset of sexual activity: _____ Currently sexual active: Yes No Partners: Male / Female / Both

# of Current Partners: _____ # of Lifetime Partners: _____ Did you receive the HPV Vaccine? Yes / No / Unsure

Do you use contraception: Yes No Type of contraception? _____

Have you ever had an STD? Yes No If so, what STDs have you had? _____

Full Name: _____ **DOB**: _____

Medical History: (circle all that apply)

Diabetes	High Blood Pressure	Heart Attack	Stroke
Asthma	Seizures	Breast Disease	Anxiety
Depression	Cancer	Thyroid Problems	Ovarian Cysts
Substance Abuse	Herpes	HIV	Hepatitis
Sickle Cell	Blood Clot in leg/lungs	Migraines	Bleeding Disorder

Other: _____

Surgical History: (circle all that apply and include date if known)

Hysterectomy _____	Tubal Ligation_____	Laparoscopy_____
Ovaries Removed _____	D&C _____	C-Section_____
Appendix Removal_____	Gallbladder Removal _____	Breast Surgery_____
Colonoscopy_____	Any other surgeries: _____	

Family History: (circle for Immediate Family Members only and list who)

Diabetes _____	Osteoporosis _____
Stroke _____	Heart Disease_____
Infertility _____	Depression _____
Substance Abuse _____	Bleeding Disorder _____
Blood Clot in legs or lungs _____	High Cholesterol _____

Cancer (type): _____

Other: _____

Social History:

Do you drink Alcohol?	Former / Current / Never	Amount per week: _____ Type: _____
Do you use drugs?	Former / Current / Never	Type: _____ Amount: _____
Do you use Tobacco?	Former / Current / Never	Vapor Cigarettes Smokeless Tobacco
		Amount: _____ Years Used: _____

Have you ever been abused?	Yes No
If yes, please circle all that apply:	Physical Emotional Sexual
Are you currently in a safe situation?	Yes No
In the past 6 months, have you felt sad, empty, or depressed?	Yes No
Are you currently receiving treatment for depression or anxiety?	Yes No
Have you ever seen a therapist/counselor/psychiatrist?	Yes No
Do you have stable housing?	Yes No
Do you have trouble with transportation?	Yes No
Do you have trouble buying food?	Yes No

Full Name: _____ **DOB**: _____

********* If you are PREGNANT, please continue********

Genetic Screenings	Yes	No
Thalassemia		
Cystic Fibrosis		
Congenital Heart Defects		
Huntington's Chorea		
Down Syndrome		
Tay-Sachs		
Fragile X		
Hemophilia		
Muscular Dystrophy		
Sickle Cell Trait or disease		
Neural tube defects (spina bifida, anencephaly, meningomyelocele)		
Other birth defect or chromosomal disorder not listed		

History of congenital disorders (birth defects) _____

Do you have a history of any of the following during pregnancy?

Preterm Labor/Delivery	Yes	No
Pre-Eclampsia/Eclampsia	Yes	No
Gestational Hypertension	Yes	No
Gestational Diabetes	Yes	No
Neonate with GBS Sepsis	Yes	No
Postpartum Hemorrhage	Yes	No
Shoulder Dystocia	Yes	No
Forceps or Vacuum Delivery	Yes	No

Do you plan to Breastfeed after delivery? Yes No Not Sure

Do you plan on permanent sterilization after this pregnancy? Yes No Not Sure

If no, what do you plan to use to prevent pregnancy after delivery? _____

I certify that all of the above information is correct.

Patient Signature: _____ Date: _____