Salem Women’s Clinic Mission Statement: To provide high quality medical care to the women of Salem in a caring and nurturing environment.

Dear: ____________________________ Date: _________________

Welcome to Salem Women’s Clinic, Inc., the first all women medical group in Salem. Dr. Harmon opened Salem Women’s Clinic in 1991, and at that time she wrote a mission statement that embodied her dream. We constantly strive to keep this mission statement evident in every aspect of your care. We have moved to our newly remodeled office at 1395 Liberty St SE. A map is included but please feel free to call for directions.

This packet of information includes forms needed for your appointment on ___________. Please fill them out and bring them with you to your appointment, along with your current insurance card and a photo ID.

❖ General Office Information:
  ➢ Office Hours: 8:00 am to 5:00 pm Monday thru Friday.
  ➢ Parking: Parking at our office is located off of Myers Street.
  ➢ Appointment Cancellation: Please give 24 hours notice to avoid a $25.00 cancellation fee.

We look forward to your visit with us and hope you will find it both comfortable and rewarding. We encourage input on how we can improve our services to our patients. Please let us know of any suggestions you may have.

Thank you for choosing Salem Women’s Clinic for your women’s health care needs.

Sincerely,

Elizebeth Harmon, M.D. & Staff
### Salem Women’s Clinic, Inc.

**PATIENT INFORMATION RECORD (Please print)**

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<th>Last Name: ___________________________</th>
<th>First: ___________________________</th>
<th>Middle Initial: ___________</th>
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<tr>
<th>Mailing Address: ____________________________________________________________</th>
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<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
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<th>Physical Address: ________________________________________________________________________________________</th>
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<th>Work Phone #: ____________________</th>
<th>Cell Phone #: ____________________</th>
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<tr>
<th>DOB: ___________________________</th>
<th>Social Security #: ______________________</th>
<th>e-mail: ______________________</th>
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<tr>
<th>Marital Status:</th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
<th>Separated</th>
<th>Divorced</th>
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<th>Driver's License #: ____________________</th>
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<th>Primary Care Physician: ___________________________</th>
<th>Phone #: ____________________</th>
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| Who Referred You to our Practice? | | |
|-----------------------------------|-----------------------------|

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<tr>
<th>Employer Name: ___________________________</th>
<th>Phone #: ____________________</th>
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| Employer Address: __________________________________________________________________________________ |
|--------------------------------------------------|------------------|------------------|
| City                                        | State            | Zip              |

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<th>Spouse's Name: ___________________________</th>
<th>Phone #: ____________________</th>
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<th>Spouse's Employer: ___________________________</th>
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<th>In case of emergency contact: (name): ___________________________</th>
<th>Phone #: ____________________</th>
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<th>Nearest friend or relative not residing with you: ___________________________</th>
<th>Phone #: ____________________</th>
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<th>Relationship to Patient: ____________</th>
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### INSURANCE BILLING INFORMATION:

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<th>PRIMARY INS</th>
<th>EFFECTIVE DATE</th>
<th>SECONDARY INS</th>
<th>EFFECTIVE DATE</th>
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<th>GROUP NUMBERS/UNION AND LOCAL</th>
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<th>RELATIONSHIP TO POLICY</th>
<th>SUBSCRIBER NAME</th>
<th>RELATIONSHIP TO POLICY</th>
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<th>Subscriber Address</th>
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<th>EMPLOYER</th>
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### IS PATIENT A MINOR? ______ IF YES, Responsible Persons Name: (Please print) ___________________________  

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<th>Relationship to patient: ___________________________</th>
<th>PH#: ____________________</th>
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| I hereby authorize the Salem Women’s Clinic to speak with the above name person regarding my account. | | |
|-------------------------------------------------------------------------------------------------|-----------------------------|

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<th>SIGN: ____________________________________________________________ Date: ___________________________</th>
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I consent to treatment necessary for the care of the above named patient or myself. I authorize the release of all medical records/information to the referring, referred, and/or family physician. I authorize the health care providers of Salem Women’s Clinic, Inc. (SWC) to release my medical information that is needed to determine insurance benefits or benefits payable to the Heath Care Finance Administration and its agents. I hereby assign to the SWC, all monies to be paid by said insurance company for services provided by SWC, but not to exceed my indebtedness to said clinic.

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<tr>
<th>Print Patient’s Name</th>
<th>Responsible Party Signature</th>
<th>Date</th>
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Account #: ____________________ Provider: ___________________________
MEDICAL HISTORY

Name ___________________________________________  Address ___________________________________________  

Date of Birth __________________  Age ______  Phone ___________________________________________

Occupation _________________________________________  Date ___________________________________________

Marital Status__________________________________________  

PROBLEM or REASON FOR VISIT ________________________________________________________________

PREGNANCY RECORD

Never pregnant_____   Full-term_____   Premature_____   Miscarriages_____   Abortions_____   Living Children_____

(Include miscarriages and abortions

<table>
<thead>
<tr>
<th>YEAR</th>
<th>HOSPITAL OF DELIVERY</th>
<th>DUR. OF PREG.</th>
<th>DUR. OF LABOR</th>
<th>DELIVERY VAG/C SEC.</th>
<th>ANESTHESIA (GEN. SPINAL EPIDURAL, ETC.)</th>
<th>WT.</th>
<th>SEX</th>
<th>HEALTH OF INFANT AT BIRTH</th>
<th>COMPLICATIONS</th>
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<td>List in sequence</td>
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MENSTRUAL HISTORY

First day of last menstrual period _______________  Age at first period __________

Number of days between 1st day of each period _____  Days flow lasts ______

Number of tampons/pads on heaviest days __________

Place an X beside any symptoms that apply to you.

_____ Recent change in periods  ____ Pain associated with periods
_____ Last period was unusual  ____ How many days does pain last? ________
_____ Bleeding between periods  ____ Does pain require medication? ________
_____ Bleeding after intercourse  ____ Periods cause you to miss work/school
_____ Pass blood clots  ____ Bloating or swelling before periods
_____ Do not menstruate  ____ Irritable before periods
_____ Hot flashes  ____ Emotional instability
_____ Night sweats  ____ Crying spells
_____ Difficulty sleeping  ____ Vaginal dryness

If you do not menstruate, is it due to _____ Pregnancy _____ Menopause _____ Hysterectomy _____ Other

Do you think you may be starting menopause? _____ Yes _____ No
BIRTH CONTROL - Place an X where applicable to you.

_____ Not sexually active
_____ Desire pregnancy
_____ Permanently sterilized
_____ Vasectomy
   _____ Tubal Ligation
   _____ Hysterectomy
   _____ Other

List contraception methods previously used

Current method of contraception:
   _____ Withdrawal
   _____ Depoprovera
   _____ Rhythm
   _____ Diaphragm
   _____ Foam suppositories
   _____ Cervical Cap
   _____ Condoms
   _____ Norplant - Year inserted 
   _____ IUD  Type  Year inserted 

_____ Birth control pills
   Name of pill ________________________________
   Dose __________________ Year started ________

If you plan to use or are now using birth control pills, place an X by any problems you have now or had in the past:

_____ High blood sugar
_____ Hepatitis or jaundice
_____ Migraine headaches
_____ High blood pressure
_____ Blood clots in veins
_____ Other

SEXUAL HISTORY

_____ Not sexually active
_____ Pain with intercourse
_____ Sexual problem
_____ Desire sexual information
_____ New sexual partner
_____ Since last exam

PAP SMEARS AND INFECTIONS

Date of last pap smear ___________________ Results ___________________ Where performed ___________________
_____ Previous abnormal paps

Current Problems
   _____ Vaginal discharge
   _____ Infection of uterus, ovaries or tubes
   _____ Vaginal irritation
   _____ Sexually transmitted diseases
   _____ Sores around vaginal area
   _____ Recurrent vaginal infections
   _____ Herpes
   _____ Genital warts or condyloma

URINARY SYSTEM

Place an X beside any symptoms that apply to you.

_____ No trouble with urinating now
_____ Trouble with urinating now
   _____ Burning
   _____ Blood in urine
   _____ Frequency
   _____ Urgency
   _____ Get up at night to empty bladder
_____ Bladder infection in Past
   How many times in the past year? __________

_____ Lose urine unintentionally
   This is a problem for you with
   _____ Coughing, straining
   _____ Without warning
   _____ Requires change of clothing or protection
   _____ Previous bladder surgery

BREASTS

Place an X beside any symptoms that apply to you.

_____ Concerned about lump now
_____ Lump removed in the past
_____ Pain in breast
_____ Change in breast size

_____ Previous mammograms or x-rays of breasts
_____ Do not check breasts routinely
_____ Family history of breast problems
### PAST HISTORY

**HOSPITAL ADMISSIONS/OPERATIONS/INJURIES:** (not for pregnancies)

<table>
<thead>
<tr>
<th>Year/Age</th>
<th>Hospital</th>
<th>Operation or reason for hospitalization</th>
<th>Problems or complications</th>
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**Childhood:**
- German measles
- Rubella vaccine
- Mumps
- Tuberculosis
- Hepatitis or jaundice
- Phlebitis
- Blood clots in lung
- Nervous breakdown
- Insurance application refused
- Diabetes

**Other Health Aspects:**
- Blood transfusions
- Injuries or fractures
- Disability
- Colitis or bowel problems
- Kidney disease
- Cancer
- Seizures, epilepsy
- Other

**Chronic Diseases:**
- Thyroid disease
- Heart disease
- High blood pressure
- Anemia
- Asthma
- Lung disease
- Stomach or gallbladder problems

### CURRENT SYMPTOMS

Place an X by those that apply to you NOW.

- Weigh gain/loss
- Ulcers
- Hemorrhoid trouble
- Heat or cold intolerance
- Food intolerance
- Blood in stools
- Oily/dry skin
- Frequent loose stools
- Painful joints
- Unusual hair growth or loss
- Chronic constipation
- Prolonged bleeding after cut or extraction
- Worrisome moles
- Routine laxative use
- Bruise easily
- Complexion problems
- Trouble breathing
- Numbness of arms/legs
- Trouble with eyes/seeing
- Chest pains
- Frequent severe headaches
- Trouble with ears/hearing
- Irregular heartbeat
- Paralysis of arms/legs
- Chronic nose or sinus trouble
- Swelling of hands/feet
- Feel nervous of anxious
- Constant cough
- (if not pregnant)
- Feel depressed
- Cough up phlegm or blood
- Stomach problems
- Marital difficulties

### PERSONAL HISTORY

- Smoke cigarettes
- How many per day? ______
- For how long? ______
- Socially use alcoholic beverages
- Excessive/problem alcohol use
- Narcotics/IV drug use
- Cocaine use
- Smoke marijuana
- Exercise regularly
- How often _____
- Special diet
- Type ________
MEDICATIONS

Place an X beside those that apply to you. 

______ I have taken female hormones in the past. Dates ________________

______ I have taken cortisone pills or shots in the past. Dates ________________

List all drugs currently used (prescription and non-prescription)

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<th>DRUG</th>
<th>DOSAGE</th>
<th>DATE STARTED</th>
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Drug Allergies:

______ None known

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<th>DRUG</th>
<th>REACTION</th>
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Family Health (Place ✓ if affected)

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<tr>
<th>Family member</th>
<th>Current age</th>
<th>Good health now</th>
<th>Cancer or malignancy</th>
<th>Arthritis</th>
<th>Allergies or asthma</th>
<th>Heart attacks</th>
<th>High blood pressure</th>
<th>Strokes</th>
<th>Kidney disease</th>
<th>Sugar diabetes</th>
<th>Nerve disease</th>
<th>Psychiatric problems (depression, panic attacks)</th>
<th>Blood disease or anemia</th>
<th>Heart disease</th>
<th>Inherited disease</th>
<th>Birth defects of inherit disease</th>
<th>Club foot, Cleft lip, etc.</th>
<th>Cause of Death</th>
<th>Age</th>
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SALEM WOMEN'S CLINIC, INC.  
HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that Salem Women’s Clinic (referred to below as “SWC”) will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that SWC may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and perform various office, administrative and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how SWC will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of SWC, and my rights regarding my health information. Our Notice of Privacy Practices is also available at our website: salemwomensclinic.com. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that SWC is not required by law to agree to such requests. I authorize my personal medical information to be released to me at my:

- Cell#____________________________  OK to leave confidential info?    YES ☐  NO ☐
- Home#___________________________  OK to leave confidential info?    YES ☐  NO ☐
- Work#___________________________  OK to leave confidential info?    YES ☐  NO ☐
- SWC Portal ______________________  OK to leave confidential info?    YES ☐  NO ☐

I also authorize my personal medical information to be released to:

- spouse/partner______________________________@#_________________________________
- parent or other: ____________________________ @ #_________________________________

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

Patient name:______________________________________  DOB_________________________
Signature:_________________________________________  Date:_________________________
By: ______________________________________________  Date: _______________________
(Patient representative)