Interior Women's Health, LLC
Request for Establishing Medical Care
Pre-Screening and Assessment Form

Today's Date:_____

Name: _____ Birth Date: _____

Phone/Home:_____Cell:_____Work:_____

New in Fairbanks? Yes [ ] No [ ]

Referral Source: Family/Friend Who? _____ Other: _____

Reason for needing a new Provider:_____

Payment method: Cash-Pay [ ] Insurance [ ]

If insurance, what type? _____

Main reason you want to be seen_____

_____

Medical problems/History:

_____

Who is your current/previous provider/clinic?

_____ Last Seen: _____

Why were you seen? _____

Hospitalizations in the Last 2 years/Where_____

List all Medications: _____

_____

Any other family members needing to establish care:

_____

Any additional information we should know, such as Allergies, Disabilities, Wheelchair, other special requirements that will assist us with the pre-screening?

_____

Note: IWH will give you an answer within 1-week should Debra Booysen, ANP-C finds the care you need and require within the scope of her professional practice. This is done to ensure that you get the right amount of care you need.

SOCIAL HISTORY Please complete all that apply		
Do you drink alcohol?	Yes No	How many drinks per week?
Do you consume drugs?	Yes No	What type of drugs?
Do you smoke?	Yes No	How many cigarettes per day?
Do you consume caffeine?	Yes No	How many years smoking?
Do you exercise?	Yes No	When did you quit smoking?
Are you sexually active?	Yes No	What is your occupation?
Marital status		Highest level of Education

FAMILY HISTORY Have any of your blood relatives (mother, father, brother, sister, grandparents) had any of the following conditions? If yes, please state relationship			
High Blood Pressure		Bleeding problems	
Heart Disease		Stroke	
High Cholesterol		Substance Abuse	
High Blood Pressure		Mental Illness	
Diabetes		Other	
Cancer (Type and Who) Breast	Colon	Prostrate	Other

MEDICAL HISTORY Please answer all questions that apply to you			
List all ALLERGIES:			
Asthma	Yes No	High blood pressure	Yes No
Blood clot in leg or lung	Yes No	High cholesterol	Yes No
Cancer (Location)	Yes No	HIV infection AIDS Tuberculosis	Yes No
Chronic bronchitis or emphysema	Yes No	Kidney disease	Yes No
Congestive heart failure	Yes No	Liver, stomach, or bowel disorder	Yes No
Depression / Anxiety	Yes No	Seizure disorder	Yes No
Diabetes	Yes No	Stroke	Yes No
Heart disease	Yes No	Thyroid disease	Yes No
Hepatitis	Yes No	Other not listed:	

MEDICATIONS/SUPPLEMENTS If taking, please list Medication, Dose, Frequency

PREVENTIVE HEALTH Please list the date/year you received any of the following:			
Colonoscopy	Eye exam	Lab tests	
Vaccines: Tetanus/Tdap	Influenza	Shingles	Pneumovax

FEMALE HISTORY	
Age at first menstrual period:	Current birth control method:
Number of pregnancies:	Year of DEXA (Bone Density) scan:
Year of last Pap:	Year of last Mammogram:

SURGICAL: List all surgeries and year. Also list recent hospitalizations and reason: