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 call you with an answer 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.

PATIENT INTAKE FORM (Please complete for all NP Booysen patients)

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

PREFERRED PHARMACY: _____ PRIMARY MEDICAL PROVIDER: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

REVIEW OF SYSTEMS Please circle any of the following you are experiencing today:

Fever Chills Fatigue Weight loss	Urine frequency/pain/incontinence	Seasonal allergies
Vision changes Eye pain	Muscle pain Joint pain or swelling	Anxiety Depression
Hearing loss Ear pain or discharge	Skin rash Bothersome skin lesion	Easy Bruising Swollen glands
Nasal congestion /discharge/drip Mouth sores Sore throat	Diarrhea Constipation Nausea Blood in stools Abdominal pain	Headache Confusion Tingling Speech problem Difficulty walking
Chest pain Palpitations Leg swelling	Breast lump Nipple discharge	Increased thirst Sweating
Cough Short of Breath Wheezing	Abnormal vaginal symptoms	Hot flashes Cold intolerance

MENSES Are your periods Regular Yes/No OR Irregular Yes/No Do you have Pain/Cramps Yes/ No
Days of Flow: _____ 1st Date of Last period: _____ Number of Days between periods: _____
# of Pregnancies: ____Living children: _____ Birth Control Method: _____

MEDICAL HISTORY: Please select if you have a personal history of any of the following:

High blood pressure	Yes/No	Asthma	Yes/No	Kidney disease or Frequent UTIs	Yes/No
Diabetes	Yes/No	Bowel Problem	Yes/No	Epilepsy or Neurological disorder	Yes/No
High Cholesterol	Yes/No	Hepatitis	Yes/No	Psychiatric Diagnosis:	
Thyroid disorder	Yes/No	Blood Transfusion	Yes/No	Cancer/Type:	
Major accident:		Blood Disorder	Yes/No	Other:	

SURGERIES Year/Type: _____

FAMILY HISTORY Please specify which blood relative, if alive and age, or age at time of death:

CONDITION	RELATIONSHIP	LIVING	DECEASED	AGE
Diabetes				
High Blood Pressure				
Heart Problem				
Lung Disease				
Kidney Disease				
Blood disorder				
Cancer				
Other:				

SOCIAL HISTORY

Marital Status:		Occupation/Employer:	
Alcoholic Drinks/day:	Drinks/week:	Illicit/Recreational Drugs/Type:	
Smoking Amount/day:	Former?	Smoking/How many years?	Ready to Quit?