Centennial Women's Health Center
231 E. 9th Ave. Suite 1A
Longmont, CO 80504
303-651-2800

To expedite your visit, please answer the following questions completely. Some of these questions may seem unusual, but an Annual exam (Well Woman Exam) is considered a Preventative Medical Exam. We ask these questions to evaluate and assess your overall health status, aiming to achieve and maintain your good health and a safe environment.

PATIENT QUESTIONNAIRE:

First Name: _____ Last Name: _____ DOB: _____ Age: _____

Reason for your Appt.: _____

Pharmacy and Location _____

Current Medications **And** Dosage: _____

_____

_____

Do you have any chronic illness such as asthma, hypertension, diabetes, etc. (If so, please list):

_____

List Any Allergies You Have **and** The Side Effects: _____

_____

_____

Please Answer ALL Questions!!!! THANK YOU!!

Do you have any problems with your periods: _____ How many days does it last?: _____
How often do they usually occur? _____ Problems with your period? _____

_____

Currently Sexually Active?: _____ If yes, is/are your partner(s) ___ Male ___ Female ___ Both
Last Pap Smear Date: _____ Last Mammogram Date: _____
Have you had an abnormal Pap Smear?: _____ If Yes, What Year?: _____
Date of Last Menstrual Period: _____ Have you ever had: Herpes _____ Chlamydia ____ Gonorrhea ____
Are you doing anything to help prevent pregnancy (including vasectomy)?: _____ If yes, what? _____
Total No. of Pregnancies: _____ Outcome of Pregnancies: Live Births after 20 weeks gestation: _____
Miscarriages (Losses prior to 20 weeks along): _____ Ectopic Pregnancies: _____
Terminations: _____ Any Pregnancies That Were Twins/Triplets/Etc.?: _____
Number of Living Children: _____ Any Problems with Your Pregnancies, And If So, What: _____

_____

_____

Have You Had Any Surgeries: _____ Please List Date and Surgery: _____

_____

_____

_____

Have you had any hospitalizations for things other than childbirth and the above listed surgeries? _____
If Yes, please describe: _____

Family History

Please include problems such as Hypertension (High Blood Pressure), Diabetes, Thyroid Problems, Cancer (please list type), Osteoporosis, Depression, Epilepsy, Heart Problems.

Mother Living/Deceased DOB: _____
Health Issues: _____
Father Living/Deceased DOB: _____
Health Issues: _____
Brothers (number) _____ DOB: _____
Health Issues: _____
Sisters (number) _____ DOB: _____
Health Issues: _____
Mat GF Living/Deceased DOB: _____
Health Issues: _____
Mat GM Living/Deceased DOB: _____
Health Issues: _____
Pat GF Living/Deceased DOB: _____
Health Issues: _____
Pat GM Living/Deceased DOB: _____
Health Issues: _____

Do your children have health issues? _____

Social History and Habits:

Do you smoke? Yes _____ No _____ If yes, how much and for how long? _____
Do you use street drugs: Yes _____ No _____ If yes, what type and how often? _____
Do you exercise? Yes _____ No _____ If yes, what type and how often? _____
Do you have a working smoke and/or carbon monoxide detector in your home? Yes _____ No _____
Do you wear your seatbelt in the car and a helmet when you bicycle? Yes _____ No _____
Do you get regular dental exams? Yes _____ No _____ If yes, when was your most recent exam? _____
Do you feel safe at home and in your relationships? Yes _____ No _____
Have you had a tetanus booster in the last 10 years? Yes _____ No _____
Do you drink alcohol? Yes _____ No _____ If yes, how much and for how long? _____
Do any of your friends/family members feel your drinking is a problem? Yes _____ No _____
Do you feel your drinking is a problem? Yes _____ No _____ Is Your Stress Level High? Yes _____ No _____

General/Review of Systems: Please circle any of the following symptoms, complaints, or problems you have had recently or in the past.

Breast Mass:
Family History of Breast Cancer
History of Breast Biopsy
Jewish Ethnicity
Other _____

Urology:
Difficulty Urinating
Blood in Urine
Frequent Urination
Urinary Incontinence
Nocturia (urinating at night)
Other _____

Hematology/Lymph:
Varicose Veins
Easy Bruising
Varicose Veins
Other _____

Allergy:
Runny Nose
Sinus Congestion
Itchy Eyes
Ear Fullness
Other _____

Respiratory:
Shortness of Breath
Wheezing
Other _____

Ophthalmology:
Diminished Vision
Eye Irritation
Drainage from Eyes
Blurring of Vision
Seasonal Eye Symptoms
Dander related to Eye Symptoms
Loss of Vision
Other _____

Neurology:
Headaches
Tingling/Numbness
Seizures
Insomnia
Gait Abnormality
Memory Loss
Dizziness
Other _____

Endocrinology:
Sleep Disturbance
Cold Intolerance
Heat Intolerance
Other _____

Constitutional:
Night Sweats
Other _____

ENT:
Cold
Cough
Other _____

Cardiology:
Chest Pain
Leg Swelling
Palpitations
Other _____

Gastroenterology:
Nausea
Heartburn
Difficulty Swallowing
Abdominal Pain
Diarrhea
Constipation
Blood in Stool
Other _____

CENTENNIAL WOMEN'S HEALTH CENTER

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to individuals, you must sign this form. Signing this form will only give consent to release this information to the following individuals indicated below. This consent form will not allow Centennial Women's Health Center to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Centennial Women's Health Center to release my medical and/or billing information to the following individuals(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Patient Name: _____

Patient's Signature: _____

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally, it is necessary for the staff at Centennial Women's Health Center to leave messages for patients. At no time will a representative of Centennial Women's Health Center discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine to call us back. We will never leave details or results unless specifically asked to!

Patient Name: _____

Patient Signature: _____ Date: _____

*** You have the right to revoke this consent in writing***

Centennial Women's Health Center

231 E. 9th Ave., Suite 1A
Longmont, CO 80504

Thank you for choosing Centennial Women's Health Center. Before we get started we would like to address some of our office policies. Please read the following and initial as needed.

Financial Policy Statement

Insurance Plans

Please feel free to discuss any concerns you have regarding this policy statement or your insurance benefits with our front office staff prior to your appointment or seeing the physician.

If your insurance provider has not paid for services in full within **60** days, you may be billed for the balance. Centennial Women's Health Center will not be responsible for billing or collecting from another party, i.e. divorced, or separated spouse. It is understood that any monies received by Centennial Women's Health Center from you or your insurance provider over and above your indebtedness will be refunded to you or your insurance provider, as is determined to be appropriate.

Your insurance card must be presented at each visit in order for charges to be submitted to your insurance provider. If for any reason your insurance coverage changes while under our care, Centennial Women's Health Center must be immediately notified of such change. *Failure to notify us of insurance changes may result in denial of your insurance claim and all monies owed will be your responsibility.* Insurance providers will **NOT** accept claims prior to the plan's effective date.
Initial: _____

Insurance Disclaimer

The information we receive from your insurance company is not a guarantee of payment. This information is not all-inclusive, other terms and limitations may apply. All claims are subject to medical review according to the information submitted and other terms of member contract.
Initial: _____

Co-Payments and Deductibles

Although we may be participating providers with your insurance plan, all co-pays, deductibles and non-covered services must be paid at the time of service. We accept cash, checks, Visa, MasterCard and Discover as forms of payment.

Initial: _____

Outstanding Balances

If you have an outstanding balance, future appointments and treatment may be denied for non-emergency services until the outstanding balance is paid in full.

Initial: _____

Collection Accounts

Outstanding balances in excess of **60** days may be sent to a collection agency. No additional appointments will be scheduled for patients that have been placed with a collection agency. A service charge of 1.75% per month (21% APR) will be added to unpaid accounts after **60** days. In the event you default, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be the greater of $30.00 or 30% of the principle balance will be added to your account. You may also be billed for any LEGAL FEES incurred as a result of default.
Initial: _____

Non-Sufficient Funds Checks

If at any time your check does not initially clear the bank, you will be notified by our office and your account status with us will be cash only as an acceptable form of payment. You will also be charges a processing fee of $35.00, which will be added to your outstanding balance.

Initial: _____

Medical Records and Medical Leave Documents

We reserve the right to charge $35 for the printing, faxing, mailing and emailing of Medical Records or the filing of Medical leave documents.

Initial: _____

Cancellations & Missed Appointments

You will be charged a $50 NO SHOW FEE for missed appointments or appointments that are NOT cancelled without a 24 hour notice.

Initial: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Forms

I have received a copy of Centennial Women's Health Centers' Notice of Privacy Practices.

Initial: _____

Release of Information

By signing below, I acknowledge primary responsibility for the payment of service to Centennial Women's Health Center. I request my claims be filed to my insurance carrier and I authorize payment of service directly to the provider. I also permit the release of medical information to the insurance carrier or case manager when the information is requested to process claims. I do not object to this information being released by mail, fax or telephone.

I have read the Financial Policy Statement, and I understand and accept its provisions.

_____

Date

_____

Signature of Patient or Responsible Party

_____

Printed Name of Patient or Responsible Party

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician Name: _____

Date of Birth: _____ Today's Date: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. **When you circle Y, please provide the family member's relationship to you, the site of their cancer and their age** when they were diagnosed with cancer.

Mother/Father/Sister/Brother/Children = 1st Degree Relatives

Aunt/Uncle/Grandparent/Niece/Nephew = 2nd Degree Relatives

Cousin/Great Grandparent = 3rd Degree Relatives

Example 1: Mother / Breast Cancer / 42 **Example 2: Uncle / Colon Cancer / 33**

- Have you or any of your relatives been tested for hereditary cancer (BRACAnalysis or Lynch/COLARIS)? YES NO
- If YES were the results positive or negative? _____

		BREAST AND OVARIAN CANCER (BRACAnalysis)	SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE/AGE	FATHER'S SIDE/AGE
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)			
Y	N	Ovarian cancer at any age (in self, first or second degree family members)			
Y	N	Two relatives on the **same side of the family** with breast cancer under the age of 50			
Y	N	Three relatives on the **same side of the family** with breast and/or ovarian cancer at any age			
Y	N	One relative with TWO separate breast cancers; one diagnosed before the age of 50 (in self, first or second degree family members)			
Y	N	Triple negative breast cancer under the age of 60 (receptor status negative for ER, PR and HER2)			
Y	N	Male breast cancer at any age			
Y	N	Breast or ovarian cancer at any age in Ashkenazi Jewish family members			
Y	N	Pancreatic cancer with 2 or more breast and/or ovarian cancers on the same side of the family			
Y	N	A family member with a known BRCA mutation			
Y	N	Are you of Jewish descent			

		COLON AND UTERINE CANCER (COLARIS)	SELF (Age at Diagnosis)	FAMILY MEMBER	
				MOTHER'S SIDE/AGE	FATHER'S SIDE/AGE
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colon cancer before age 50			
Y	N	Two or more (at any age) of the following cancers on the same side of the family: colon, uterine (endometrial), ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis			
Y	N	A family member with a known Lynch Syndrome mutation			

- Is there any other cancer in you or any family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer:

_____

Patient's signature: _____ **Today's Date:** _____

FOR OFFICE USE ONLY

O Patient is not appropriate for further risk assessment and/or genetic testing assessment and/or genetic testing

O Patient is appropriate for further risk assessment and/or genetic testing assessment and/or genetic testing

Patient offered genetic testing: Accepted OR Declined

O Discussed genetic testing and information given to patient to review. Follow-up appointment scheduled on _____

HCP Signature: _____