Center For Women's Health

Offices at Cranbrook ▪ 10111 East 21st Street North ▪ Suite 301 ▪ Wichita, KS 67206

316-634-0060 ▪ 316-634-0050 (fax) ▪ cwhwichita.com

PATIENT INFORMATION

Last Name:	**First Name:**		
Address:	City:	State:	Zip Code:
Phone Number:	Marital Status:	Social Security Number:	
Primary Care Provider:	DOB:	Referring Physician:	
Email Address:		Significant Other's Name:	
Place of employment:			
Ethnicity:		Primary Language:	
Preferred Pharmacy:			

INSURANCE INFORMATION:

Primary Carrier:	Policy Holder's Name/D.O.B.: ☐ Self
Member ID:	Group Number:
Medical Claims PO Box:	

CONSENT TO TREATMENT:

I hereby grant consent for treatment or services to be provided by the providers of Center for Women's Health. I also certify that no guarantee or assurance has been made regarding the result that may be obtained.

QUEST DIAGNOSTICS:

Center for Women's Health uses Quest Diagnostics as our in-office laboratory vendor. Laboratory services including blood draw, pap smears, cultures or biopsies done in our office will be sent to Quest Diagnostics.

It is your responsibility to know if Quest Diagnostics is your in-network laboratory vendor.

If you do not want your laboratory services to be sent to Quest Diagnostics, please write your preferred laboratory vendor name below. We may be able to schedule a pick up for this specimen, otherwise you will need to take the lab order to your designated laboratory vendor.

Preferred Laboratory Vendor:

By signing this form, you acknowledge that you have consented to treatment as stated above as well as to using Quest Diagnostics as your laboratory vendor, unless you listed an alternative vendor.

Patient Signature:	**Date:**
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:

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Annual Gynecological Update

WELCOME BACK! Thank you for taking time to complete this form to help us accurately update your health history.

Patient Name:	**Date of Birth:**	**Today's Date:**
Are you here today for your Annual Well Women Exam? □ Yes □ No		
Are you here for a gynecological problem? □ Yes □ No If yes, please list your problem:		
Would you like to be tested for sexually transmitted infections? □ Yes □ No		
Who is your PCP (primary care physician)?		
When was the first day of your last period?	Are you periods regular? □ Yes □ No	
How many days between cycles?	How many days of bleeding (including spotting)?	
How heavy is the bleeding? □ Mild □ Moderate □ Moderate to Heavy □ Heavy		
Have you been diagnosed with any new medical problems since your last visit? □ Yes □ No If yes, please list:		
Have you had any surgeries since your last visit? □Yes □ No. If yes, please list (with date of procedure):		
Have there been any newly diagnosed medical problems in your family? □ Yes □ No If yes, please list:		

Current medications: (If you have a medication list available, please alert staff so that we can make a copy)

Prescription Name/Dose/Frequency: □ Check if NONE.		
Supplements/Over the counter medications Name/Dose/Frequency: □ Check if NONE.		

Please list any allergies you have:	
Do you smoke? □ Yes □ No If yes, how much?	
Do you drink alcohol? □ Yes □ No If yes, how much per week?	
Do you use illicit drugs? □ Yes □ No If yes, what type of drug?	
Do you have concerns with violence at home? □ Yes □ No	Do you exercise regularly? □ Yes □ No
Do you wear sunscreen? □ Always □ Usually □ Sometimes □ Never	
Are you exposed to occupational or recreational hazards? □ Yes □ No	
Do you wear your seatbelt while riding or driving a car? □ Always □ Usually □ Sometimes □ Never	
Do you perform monthly self-breast examinations? □ Yes □ No	
What is your current method of contraception? □None □Condoms□Spermicidal □Depo-Provera □Nexplanon □ IUD:_____ □Birth control pill:_____ □Birth control patch □Birth control ring □Tubal ligation □Vasectomy □ Other:	
Are you satisfied with this current method? Yes No	
Date of last pap smear: □Normal □Abnormal. Treatment (if any):	Date of last mammogram: □Normal □Abnormal □Additional Diagnostics (if any):
Date of last bone density: □Normal □Abnormal Treatment (if any):	Date of last colonoscopy: □Normal □Abnormal. When do you need to have a repeat test? ____Yrs
Have you had any recent blood work/labs/x-rays in the past year? □ Yes □ No If yes, please list:	
When was your last TDaP/Tetanus Vaccine?:	Have you had HPV vaccine? □ Yes □ No

Family History Screening Form

Patient Name: _____ Date of Birth: _____ Age: ____ Height: _____ Weight: _____
Your age at First Period: _____ Your age at First Childbirth (if applicable): _____ Are you Menopausal: Yes or No
If yes, your age at Menopause: ____ Have you ever used Hormone Replacement Therapy? Yes or No If yes, for how long? _____
Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please indicate if you have a **personal or family history** of any of the following cancers. If yes, then **write family relationship** and **AGE at diagnosis**. **Consider parents, children, brothers, sisters, half- siblings, grandparents, aunts, uncles, nieces, nephews.**

BREAST AND OVARIAN CANCER (HBOC)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	**EXAMPLE:** *Breast Cancer*	_____	_____	*Aunt 53*	*Grandmother 45*
Y	N	**Breast Cancer**				
Y	N	**Breast Cancer in both breasts OR multiple primary breast cancers**				
Y	N	**Ovarian cancer** *(Peritoneal/Fallopian Tube)*				
Y	N	**Male breast cancer**				
Y	N	**Are you of Ashkenazi Jewish descent?**				

COLON AND UTERINE CANCER (LYNCH)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	**Endometrial (uterine) cancer**				
Y	N	**Colon/Rectal cancer**				
Y	N	**Ovarian, stomach, kidney, brain OR small bowel cancer** **Please specify relatives, type of cancer & their age at diagnosis.*				
Y	N	**10 or more colon polyps in a lifetime** *(Specify #)*				
Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Melanoma (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lynch)**				
Y	N	**Other Cancers** **Please specify relatives, type of cancer & their age at diagnosis.*				

Patient's Signature: _____ Date: _____

For Office Use Only:
Patient offered hereditary cancer testing?
☐ YES ACCEPTED DECLINED
☐ NO

HEALTH CARE PROVIDER SIGNATURE: _____

1st degree: parents, siblings, children. 2nd degree: grandparents, aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.

HBOC - Personal or Family History

One person with: (out to 2nd degree)
-Breast (diagnosed ≤45)
-Ovarian, any age
-Male breast, any age
-Breast with Ashkenazi Jewish heritage, any age
-Bilateral breast (diagnosed ≤50)
-Triple Negative breast (diagnosed ≤60)

Two persons with: (out to 3rd degree)
-Breast cancer (1 diagnosed ≤ 50)
-Breast & Ovarian Cancer, any age

Three Persons with: (out to 3rd degree)
-Breast and/or Pancreatic and/or Ovarian, any age

Lynch*- Personal or Family History

One or Two persons with: (out to 2nd degree)
-Endometrial or Colorectal cancer (1 diagnosed ≤50)
-Endometrial or CRC cancer (1 ≤50) & another Lynch* cancer, any age

Three persons with: (out to 2nd degree)
-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Lynch cancers: endometrial, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaccous adenomas

PATIENT NAME: _____ DATE: _____

REASON FOR TODAYS VISIT: _____LMP:_____

GENERAL:
- ☐ Weight loss
- ☐ Weight Gain
- ☐ Fever/ Chills
- ☐ Fatigue/ Weakness

SKIN:
- ☐ Nail Changes
- ☐ Hair Changes
- ☐ Mole Changes
- ☐ Skin Rashes
- ☐ Itchy Skin

EYES:
- ☐ Blurred/ Double Vision
- ☐ Glaucoma/ Cataracts
- ☐ Dry/ Itchy eyes
- ☐ Eye Glasses/Contact Lenses

EARS:
- ☐ Hard of Hearing
- ☐ Hearing Changes/ Deafness
- ☐ Ringing in Ears
- ☐ Ear Discharge
- ☐ Earache
- ☐ Dizziness

NOSE:
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip

MOUTH:
- ☐ Bleeding Gums
- ☐ Oral sores/ulcers
- ☐ Dental Problems
- ☐ Loss of Taste

THROAT:
- ☐ Difficulty Swallowing
- ☐ Throat Pain
- ☐ Hoarseness

NECK:
- ☐ Stiffness
- ☐ Soreness
- ☐ Pain
- ☐ Masses

BREAST:
- ☐ Nipple Discharge
- ☐ Lumps/Nodules
- ☐ Pain/Tenderness
- ☐ Breast Masses
- ☐ Nipple Bleeding

LUNGS:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

HEART:
- ☐ Murmur
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Chest Pain

GASTROINTESTINAL:
- ☐ Change in Appetite
- ☐ Difficulty Swallowing
- ☐ Abdominal Pain
- ☐ Nausea/ Vomiting
- ☐ Bloating/ Gas
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal Bleeding

GENITOURINARY:
- ☐ Urgency
- ☐ Incontinence
- ☐ Frequency
- ☐ Pain with Urination
- ☐ Bloody Urine
- ☐ Urination at Night

BLOOD:
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Swollen Lymph Nodes
- ☐ Painful Lymph Nodes

GYNECOLOGIC:
- ☐ Break Through Bleeding
- ☐ Labial Sores
- ☐ Labial lumps/nodules
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Painful Intercourse
- ☐ Menstrual Cramps
- ☐ Pain Between Periods
- ☐ Postmenopausal Bleeding
- ☐ Irregular menses
- ☐ Loss of Sexual Desire
- ☐ Night Sweats
- ☐ Vaginal Odor
- ☐ Pelvic Pain
- ☐ Infertility

MUSCULOSKELTAL:
- ☐ Muscle Pain/Cramps
- ☐ Weakness
- ☐ Joint Pain/Swelling

NEUROLOGICAL:
- ☐ Seizures
- ☐ Vertigo
- ☐ Paralysis
- ☐ Tingling/Numbness

PSYCHIATRIC:
- ☐ Depression
- ☐ Irritability
- ☐ Anxiousness
- ☐ Alcohol Abuse
- ☐ Suicidal Thoughts
- ☐ Sexual Difficulties
- ☐ Panic Attack
- ☐ Drug Addiction
- ☐ Physical Abuse

ENDOCRINE:
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Loss of Hair
- ☐ Extreme Thirst
- ☐ Excessive Hair Growth
- ☐ Hypoglycemia/Low Blood Sugar

OTHER CONCERNS:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Center For Women's Health

SYMPTOM CHECKLIST FOR WOMEN

bioTE® MEDICAL

Name: _____ **Date:** _____

SYMPTOMS	NEVER	MILD	MODERATE	SEVERE
Please check symptoms you are experiencing				
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/ libido				
Difficulty in climaxing / achieving an orgasm				
Sleep problems				
Mood changes / irritability / tension				
Migraines / severe headaches				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Feeling cold all of the time				
Joint Pain				
Swelling all over the body				