Comprehensive Women's Health Services, PLLC

Name	Do	OBSS	N			
Address			Apt #			
City	State	Zip	Code			
Phone #	Cell #	Worl	k#			
How do you prefer to be	contacted: Home (Cell Work Mail				
Emergency Contact Name	9	Pho	ne #			
Primary Care Physician _		Pho	Phone #			
Address		City	State			
Pharmacy		Pho	one #			
Prescription preference:	30 day supply or 90	day supply				
Person financially respon	sible for the account					
Relationship to patient _		DOB S	SN			
Address if different than	above					
Primary Insurance		Secondary Insura	ance			
Do you have a Health Ca	re Proxy or Power of	Attorney? If so, ple	ase provide a copy.			
Signature		Date				

COMPREHENSIVE WOMEN'S HEALTH SERVICES, PLLC

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND OTHERS

I,, authorize Comprehensive Women's Health Services, PLLC to disclose my protected health information for the purposes of communicating with the family members or others I have designated below. I specifically authorize any current employee or physician of Comprehensive Women's Health Services, PLLC to use or disclose the protected health information as described on this form to the recipients listed below. Description of the information to be disclosed (check all that apply):				
[]	Medical Data/Information as related to: [] Specific condition(s): [] Specific professional service(s):			
• •	[] Specific professional service(s): [] Specific medication(s): [] Other:			
[]	The patient's billing/payment information:			
[]	Other:			
the Pri	orized recipients of the protected health information (list individuals to whom actice may disclose):			
must b [] T [] T	information will be used/disclosed for the following purpose(s): (all purposes be checked) To coordinate my care/treatment To assist in my billing This directed by the patient (Check if applicable) This authorization permits Comprehensive Women's			
	Services, PLLC discuss the above designated information in person or by one or by fax.			

This authorization has been given voluntarily. I understand that unless otherwise permitted by law, Comprehensive Women's Health Services, PLLC will not condition treatment or payment on this authorization. I further understand that I have a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

I understand that I may revoke this authorization at any time by notifying Comprehensive Women's Health Services, PLLC's Privacy Officer, [INSERT NAME OF PRIVACY OFFICER], in writing, except that revocation may not be valid if Comprehensive Women's Health Services, PLLC has taken action in reliance on this authorization. In order for the revocation to be effective it must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the signature of the patient or authorized representative.

This authorization will expire	After th	After this date,				
Comprehensive Women's Health Services, PLLC can no longer use or disclose the						
protected health information without first obtaining						
protected meaning management with the committee						
D 1D						
Patient or Personal Representative's Signature	Date					
Printed name of Patient or Personal Representative						
FOR OFFICE USE ONLY						
TOR OTTICE OSE ONET						
Audhaniantian mituaan diba						
Authorization witnessed by						
Authorization added to the patient's medical record	ion					

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Comprehensive Women's Health Services, PLLC

RESPONSIBILITY AGREEMENT

Please be advised that many insurance policies will not cover Annual Screening/Preventative Exam, Well Woman exam or any other exam, if you have had this service performed within the last 12 months or time limit outlined by your insurance policy. If this exam has been performed within the last 12 months or the time limits of your insurance policy, you may not be covered or you will be responsible for some, if not all of the financial obligations your insurance carriers deem your responsibility. Please check your individual insurance policies for limitations on this service.

I have read the above and agree to pay a	ny charges not covered by my insurance policy.
Patient Name (Print)	Date
Patient Name (Signature)	

Primary Care Doctor: Reason for visit:	Last Name:	PATIE	NT HISTORY FORM	(Please Prin	t) Office Use First Name:	Only: ID):	
MENSTRUAL HISTORY MENSTRUAL HISTORY Age at 1st Menstrual Period: Age at	Primary Care Doctor				Reason for visit			
Last Menstraul Period: Age at 1st Menstraul Period: # Days: # Perterm Vag Deliveries # Fall term C-Sect # Elective Period: # Days:	Timary Care Doctor.							
Last Mammogram: Last Manstrual Period: Age at 1st Morstrual Period: # Days: # Days: # Days: # Days: # Pall term Age at 1st Morstrual # Deliveries # Pall term Age at 1st Morstrual # Pall term Age at 1st Morstrual # Pall term Age Deliveries # D	MENSTRUAL HIS	TORY		OBSTET	RICAL HISTORY	(List nu	imber of pregnancies)	
Frequency: # Weeks or Amount: light Irregular: (check) (check) normal heavy	Last Menstrual Period: Age at 1st Menstrual		Pave:	Vag I # Full	Deliveries De term # F	eliveries Full term C	# Miscarriages C-Sect # Elective	
Appendectomy Appe	Frequency: # Weeks:							
Dec C Hysterectomy Other		All						
Method of Birth Control (check one) Abstinence DepoProvera Conford DepoProvera Condoms Withdrawal Vasectomy Condoms Withdrawal Vasectomy Contraceptive Patch/ring IUD Other None None None MEDICAL/FAMILY HISTORY Check problems you (P) or your family (F) have or had: PF PF FF F	Irregular: (check)	(c)		Appendectomy		Gall Bla	dder Tonsillectomy	
Abstinence DepoProvera contractives None Blood Pressure Hormones			heavy			Hystered	ctomy Other	
Condoms			Oral .			Dland D	Hormonas	
Contraceptive Patchring UD Other Other Contraceptive Heart Other						Blood P		
MEDICAL/FAMILY HISTORY Check problems you (P) or your family (F) have or had: P F Arthritis Anemia Arthritis Asthma Lung Disease Bladder Problems Clots in veins Clots in veins Blood Transfusion Blood Transfusion Blood Transfusion Blood Pressure Blood Pressure Bligh Blood Pressure Blood Diabetes Blood Diab				Anti-	Depressant	Diabetes	Thyroid	
MEDICAL/FAMILY HISTORY Check problems you (P) or your family (F) have or had: P P P P P P P P P P P P P P P P P P P	Patch/ring	IUD	Other	Cont	raceptive	Heart	Other	
Check problems you (P) or your family (F) have or had: PF F G Anemia			None	DRUG A	LLERGIES			
Anemia			v (F) have or had:	None	None Penicillin		n Other	
Asthma	P F	P	F	Code	ine	Shellfish		
Asthma	Anemia		Kidney Stones	SOCIAL	HISTORY			
Bladder Problems	Arthritis		Hepatitis	Status:	Married	Single	Divorced Widow	
Clots in veins Clot in veins Clots in veins Clots in veins Clots in veins Clot in veins Clots in veins Clot in veins Clots in veins Clot in that apply; (C) Current (P) Previous Clot clot in that apply; (C) Current (P) Previous Clot clot in that apply; (C) Current (P) Previous Clot clot in that apply; (C) Current (P) Previous Clot clot in that apply; (C) Current (P) Previous Clot clot all that apply; (C) Current (P) Previous Clot clot all that apply; (C) Current (P) Previous Clot clot all that apply; (C) Current (P) Previous Clot clot all that apply; (C) Current (P) Previous Check all that apply; (C) Cu	Asthma		Lung Disease	Employed	: Yes	No	(Cl1. 'CV)	
Blood Transfusion Reflux Diabetes Stroke Diabetes Stroke CURRENT/PREVIOUS MEDICAL CONCERNS (check all that apply; (C) Current (P) Previous) C P Weight change Bleeding between periods Intestinal Disease Ovarian Cancer Intiable Bowel Syndrome Syndrome Kidney Disease Colon Cancer Kidney Disease Colon Cancer Other Cancer SEXUAL HISTORY Age of first sexual Intercourse Age of first sexual Intercourse Females Males Both Males Both Males Both GYNECOLOGIC HISTORY (Month/year) Last Mammogram: Check problems you have or had: Alcohol drinks per wk: Seatbelt use Exercise: Yes No Physical/Sexual Abuse CURRENT/PREVIOUS MEDICAL CONCERNS (check all that apply; (C) Current (P) Previous) Check all that apply; (C) Current (P) Previous Check problems you have or had:	Bladder Pro	blems	Lupus	Cigarettes	per day:		The second secon	
Blood Transfusion	Clots in veir	ıs	Osteoporosis	Alcohol d	Alcohol drinks per wk: Seathelt use			
Diabetes Stroke Heart Disease Thyroid Check all that apply; (C) Current (P) Previous) C P Weight change Bleeding between periods High Cholesterol Breast Cancer High Cholesterol Diritable Bowel Syndrome Syndrome Syndrome Colon Cancer Widney Disease Colon Cancer Check all that apply; (C) Current (P) Previous) C P Weight change Bleeding between periods Heavy vaginal bleeding Weight change Bleeding between periods Heavy vaginal discharge Uterine Cancer Syndrome Syndrome Syndrome Colon Cancer Weight change Bleeding between periods Heavy vaginal discharge Uterine Cancer Sinus congestion Painful intercourse Weight change Bleeding between periods Heavy vaginal discharge Userine Cancer Sinus congestion Painful intercourse Weight change Bleeding between periods Heavy vaginal discharge Userine Cancer Sinus congestion Painful intercourse Weight change Bloeding between periods Heavy vaginal discharge Userine Cancer Sinus congestion Painful intercourse Cough/wheezing/ difficulty breathing Bloody sputum Breast pain/discharge/mass Bloody sputum Breast pain/discharge/mass Bloody sputum Breast pain/discharge/mass Diarrhea Fainting episodes Constipation Mood changes/depression/ Anxiety Bloody stools Heat/cold intolerance	Blood Trans	sfusion	Reflux	Exercise				
Heart Disease High Blood Pressure	Diabetes		Stroke	1 cs 1 to 1 trysteat/ Sexual Atouse			· ·	
High Cholesterol Breast Cancer Intestinal Disease Ovarian Cancer Irritable Bowel Syndrome Uterine Cancer Kidney Disease Colon Cancer Other Cancer SEXUAL HISTORY Age of first sexual Intercourse of sexual partners of sexual partners of sexual activity: Never Females Males Both Males Both CYNECOLOGIC HISTORY (Month/year) Last pap smear: Hearing loss Pelvic pain Cough/wheezing/difficulty breathing Seizures Bloody sputum Breast pain/discharge/mass Mood changes/depression/Anxiety Bloody stools Heat/cold intolerance	Heart Disease		Thyroid	(check all that app				
Intestinal Disease Ovarian Cancer Irritable Bowel Syndrome Uterine Cancer Kidney Disease Colon Cancer Other Cancer SEXUAL HISTORY Age of first sexual Intercourse 4 or more Cough/wheezing/difficulty breathing Skin rashes Sexual activity: Never Females Bloody sputum Breast pain/discharge/mass Males Both Nausea/vomitting Scizures GYNECOLOGIC HISTORY (Month/year) Diarrhea Fainting episodes Mood changes/depression/Anxiety Bloody stools Heat/cold intolerance Intercourse Vaginal discharge Low sex drive/ sexual dysfunction Last Mammogram: Difficulty sleeping Vaginal discharge Low sex drive/ sexual Chest pain/gloss Pelvic pain Pelvic pain Chest pain/palpitations Pelvic pain Skin rashes Breast pain/discharge/mass Mood changes/depression/Anxiety Check problems you have or had:	High Blood	Pressure	Ulcers	1	Weight change		Bleeding between periods	
Irritable Bowel Syndrome Kidney Disease Colon Cancer Other Cancer SEXUAL HISTORY Age of first sexual Intercourse of sexual partners of sexual partners Sexual activity: Never Females Both Males Both Nausea/vomitting Seizures Constipation Difficulty sleeping Females Sinus congestion Painful intercourse Pelvic pain Cough/wheezing/difficulty breathing Breast pain/discharge/mass Breast pain/discharge/mass Seizures Constipation Diarrhea Fainting episodes Mood changes/depression/Anxiety Constipation Bloody stools Heat/cold intolerance	High Choles	sterol	Breast Cancer	I	Fever/chills		Heavy vaginal bleeding	
Syndrome Uterine Cancer Eyes Low sex drive/ sexual dysfunction			Ovarian Cancer	I	Difficulty sleeping		Vaginal discharge	
Other Cancer SEXUAL HISTORY Age of first sexual Intercourse # of sexual partners Sexual activity: Never Females Both Nausea/vomitting GYNECOLOGIC HISTORY (Month/year) Last Mammogram: Coutoff Cancer Sinus congestion Painful intercourse Painful intercourse Chest pain/palpitations Pelvic pain Cough/wheezing/ difficulty breathing Bloody sputum Breast pain/discharge/mass Seizures Fainting episodes Mood changes/depression/ Anxiety Constipation Bloody stools Heat/cold intolerance	Syndrome	e 📙					Low sex drive/ sexual	
SEXUAL HISTORY Age of first sexual Intercourse < 18 yrs old > 18 yrs old Chest pain/palpitations Pelvic pain # of sexual partners 3 or less 4 or more Cough/wheezing/difficulty breathing Skin rashes Sexual activity: Never Females Bloody sputum Breast pain/discharge/mass Males Both Nausea/vomitting Seizures GYNECOLOGIC HISTORY (Month/year) Diarrhea Fainting episodes Last pap smear: Diarrhea Fainting episodes Mood changes/depression/Anxiety Bloody stools Heat/cold intolerance Check problems you have or had:	Kidney Dise	case		I	Hearing loss			
Age of first sexual Intercourse			Other Cancer	5	Sinus congestion		Painful intercourse	
# of sexual partners 3 or less 4 or more Cough/wheezing/difficulty breathing Sexual activity: Never Females Bloody sputum Breast pain/discharge/mass Males Both Nausea/vomitting Seizures GYNECOLOGIC HISTORY (Month/year) Last pap smear: Diarrhea Fainting episodes Mood changes/depression/Anxiety Check problems you have or had: # of sexual partners 3 or less 4 or more Cough/wheezing/difficulty breathing Bloody sputum Breast pain/discharge/mass Skin rashes Skin rashes Skin rashes Breast pain/discharge/mass Fainting episodes Mood changes/depression/Anxiety Heat/cold intolerance	Age of first sexual		d > 18 yrs old		Chest pain/palpitations		Pelvic pain	
Sexual activity: Never Females Bloody sputum Breast pain/discharge/mass Males Both Nausea/vomitting Seizures GYNECOLOGIC HISTORY (Month/year) Last pap smear: Last pap smear: Constipation Bloody stools Heat/cold intolerance		3 or less	4 or more				Skin rashes	
GYNECOLOGIC HISTORY (Month/year) Last pap smear: Last Mammogram: Constipation Bloody stools Heat/cold intolerance	Sexual activity:	Never	Females				Breast pain/discharge/mass	
Last pap smear: Constipation Constipation Constipation Anxiety Bloody stools Heat/cold intolerance			1	Nausea/vomitting		Seizures		
Last Mammogram: Constipation Constipation Anxiety Bloody stools Heat/cold intolerance		HISTORY (N	/lontn/year)	I	Diarrhea		Fainting episodes	
Last Mammogram: Check problems you have or had: Bloody stools Heat/cold intolerance		/			Constipation			
Check problems you have or had:			I	Bloody stools		•		
Abnormal pap smears Infertility Frequent urination Excessive thirst or urination	prompt of the control		I	requent urination		Excessive thirst or urination		
					Painful/blood urination		Hot flashes	
Endometriosis Painful Periods Painful/blood urination Hot flashes Fibroids Sexually Transmitted Diseases Leakage of urine Abnormal bruising/bleeding								