Women's Health Connecticut
CCOG Women's Health Group
Member of Women's Health Connecticut

Devoted to women, committed to excellence.

Obstetrics and Gynecology
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# New Patient Questionnaire

Name _____ Date _____

Date of Birth_____ Race _____

Height_____ Weight_____ Religion _____

Employer _____ Occupation _____

Primary Care Physician_____

Pharmacy _____ _____ _____
(Street Address) (City)

**PLEASE LIST ANY MEDICAL PROBLEMS AND TREATING PHYSICIAN:**

1. _____
2. _____
3. _____

**PLEASE LIST ALL SURGICAL PROCEDURES:**

| | Year | Type of Surgery | Reason for Surgery | Complications |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Age of first period_____ Last menstrual period_____ How long do your periods last?_____

How often do you receive your periods? _____ Are your periods regular or irregular?_____

Are you: **Pre** ☐ / **Peri** ☐ / **Post** ☐ menopausal Number of years on Hormone Replacement Therapy_____

**PLEASE LIST ALL PREGNANCIES:**

| | Date of Delivery | Sex | Type of Delivery/Complications |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |



Revised: 6/15/12

**PLEASE LIST PREGNANCY MISCARRIAGES OR TERMINATION:**

| Date | Surgery Performed/Complications |
|---|---|
| 1. | |
| 2. | |
| 3. | |

**FAMILY HISTORY:** Do you or any relative have:

| | Relationship to Patient | Maternal or Paternal | Type |
|---|---|---|---|
| Heart Disease | | | |
| High Blood Pressure | | | |
| Diabetes | | | |
| Birth defects/retardation | | | |
| Cancer (Please specify type) | | | |
| Other Medical/Psychiatric Problems | | | |

**SOCIAL HISTORY:**

Do you smoke? _____ If yes, how much_____

Do you drink? _____ If yes, how often_____

Are you sexually active? Yes ☐ No ☐ With: Men ☐ Women ☐ Both ☐

What form of birth control do you use? _____

**PLEASE LIST ANY MEDICATIONS INCLUDING DOSAGE:**

_____ _____

_____ _____

**PLEASE LIST ANY ALLERGIES**:

| Allergy | Type of Reaction |
|---|---|
| | |
| | |
| | |

**PLEASE CHECK IF YOU ARE CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:**

☐ Chest pain ☐ Decrease in appetite ☐ Frequent urination

☐ Irregular heart beat/palpitations ☐ Painful urination ☐ Blood in urine *(Cont'd)*

☐ Chills/fever
☐ Increased thirst
☐ Ear infections
☐ Vision changes
☐ Weight gain or loss
☐ Diarrhea
☐ Vaginal itch/discharge
☐ Incontinence
☐ Wheezing

☐ Sexual problems
☐ Headache
☐ Asthma
☐ Swelling
☐ Sore throat
☐ Vomiting
☐ Bleeding conditions
☐ Depression

☐ Skin changes
☐ Anxiety
☐ Shortness of breath
☐ Cold/heat intolerance
☐ Constipation
☐ Nausea
☐ Back pain
☐ Chronic cough

How did you hear about CCOG? Family ☐ Friend ☐ Ad ☐ Internet ☐

Other _____

Women's Health Connecticut

www.womenshealthct.com

*For Internal Use Only*
*PT ID Number*
*Last Verified* _____

## Patient Information

Last Name_____ First Name_____ M.I._____ Maiden or Nickname_____

Street Address_____ Apt._____ PO Box_____ City_____

State_____ Zip_____ DOB_____ Last Four Digits of SS#_____ Preferred Language_____

**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other **Ethnicity** ☐ Hispanic ☐ Non-Hispanic

**Race** ☐ Asian ☐ Black ☐ Caucasian ☐ Multi-Racial ☐ Native American ☐ Pacific Islands ☐ Other

**H**ome phone:_____ **W**ork phone:_____ Ext_____ **C**ell phone:_____
Primary # to call me: ☐ **H** ☐ **W** ☐ **C**

Email address_____ May we email you for other than medical reasons? ☐ Yes ☐ No

Employer_____ Employer Address_____

Occupation_____ If Student ☐ Full time ☐ Part time School Name_____

## Insurance Information Do you have health insurance? ☐ Yes ☐ No

**Primary Insurance**_____ Insurance Address_____

Policy #_____ Group #_____ Copay_____

Policy Holder_____ DOB_____ Relationship_____

**Secondary Insurance**_____ Insurance Address_____

Policy #_____ Group #_____ Copay_____

Policy Holder_____ DOB_____ Relationship_____

***Complete for Policy Holder if other than self:*** Last Four Digits of SS#_____ Employer_____

Employer Phone #_____ Employer Address_____

## Other Information

May we have your consent to obtain the list of all your current medications from pharmacy networks? ☐ Yes ☐ No

Primary Care Physician_____ Referring Physician_____

Primary Physician in This Office_____ Pharmacy Name & Phone_____

## In case of Emergency/Urgent matter, we may contact: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

Name_____ Relationship_____ Phone #_____

**Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ☐ Yes ☐ No**

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

### Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand an acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

**Signature of Patient or Parent of Minor** **Date**

### Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

**Patient's Signature** **Date**

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**Notice of Privacy:** ☐ Received ☐ Refused _____
**Signature of Patient or Parent of Minor** **Date**

May release protected health information to: _____
**Name** **Relationship**