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Welcome to Jefferson Women's Primary Care. We are looking forward to your visit. Please arrive 15 to 20 minutes ahead of this scheduled time in order to register.

We have enclosed a Medical History Form for you to fill out before your appointment which will make your visit move along more smoothly. Please also remember to bring the following:

- All paperwork and old records from visits to any medical office or hospital.
- An up-to-date list of ALL your medications and dosages or ALL your medicine bottles
- Insurance cards for both health and pharmacy
- Photo ID
- Cash, check or credit/debit card to cover co-pay which will be collected at time of check in. (An ATM machine is available at the entrance).

Jefferson Women's Primary Care is located on the ground floor of Walnut Towers (the tall building with the curved corner at 9<sup>th</sup> & Walnut), 834 Walnut Street, Suite #110. The entrance to 834 is on Walnut Street between 8<sup>th</sup> and 9<sup>th</sup> Street, between Wills Eye Hospital and Citizens Bank. Suite #110 is located straight down the hall just past the security desk.

Parking is available in Walnut Towers (entrance on 9<sup>th</sup> Street) and there is a modest discount provided to our patients (ask at the time of signing out). There are many other parking lots available nearby and street parking is available between 10AM and 3:30PM. There are many ways to reach us by SEPTA and New Jersey Transit.

We at Jefferson Women's Primary Care are committed to providing comprehensive, compassionate care based on the most up to date research in women's health. We are looking forward to collaborating with you to build long term health and well-being.

Sincerely,

Staff of Jefferson Women's Primary Care

MRN # \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Provider you are seeing today: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please state your problem in your own words as to why you are here today: \_\_\_\_\_

 Did a physician request that you see one of our providers today?  Yes  No If yes, name of physician: \_\_\_\_\_

**Past Medical History (check all that apply):**  No Past Medical History

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Acute Myocardial Infarction (Heart Attack) | <input type="checkbox"/> Chronic Liver Disease                        | <input type="checkbox"/> Kidney Disease                                   | <input type="checkbox"/> Seizure Disorder                             |
| <input type="checkbox"/> Anemia (Low Blood Count)                   | <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease) | <input type="checkbox"/> Lower Back Pain                                  | <input type="checkbox"/> Sinusitis                                    |
| <input type="checkbox"/> Arthritis                                  | <input type="checkbox"/> Diabetes Mellitus                            | <input type="checkbox"/> Mitral Valve Disorder                            | <input type="checkbox"/> Stroke Syndrome                              |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Emotional Disturbance                        | <input type="checkbox"/> Murmurs  | <input type="checkbox"/> Thromboembolic Disease (Blood Clot Disorder) |
| <input type="checkbox"/> Autoimmune Disorder (Lupus/Scleroderma/RA) | <input type="checkbox"/> Gastric/Duodenal Ulcer                       | <input type="checkbox"/> Obesity  | <input type="checkbox"/> Thrombophlebitis                             |
| <input type="checkbox"/> Blood Transfusion Complications            | <input type="checkbox"/> Heart Disease                                | <input type="checkbox"/> Obstructive Sleep Apnea                          | <input type="checkbox"/> Thyroid Disorder                             |
| <input type="checkbox"/> Cancer - list type(s):<br>_____<br>_____   | <input type="checkbox"/> Heartburn                                    | <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Transient Ischemic Attack (Mini Stroke)      |
|   | <input type="checkbox"/> Hepatic (Liver) Disorder                     | <input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation)   | <input type="checkbox"/> Tuberculosis                                 |
|   | <input type="checkbox"/> Hepatitis                                    | <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Other (specify):<br>_____<br>_____           |
|   | <input type="checkbox"/> HIV Infection                                | <input type="checkbox"/> Pulmonary Disease (Lung Disease)                 |   |
|   | <input type="checkbox"/> Hypercholesterolemia                         | <input type="checkbox"/> Recent Methicillin-resistant Staph aureus (MRSA) |   |
| <input type="checkbox"/> Chest Pain (Angina)                        | <input type="checkbox"/> Hypertension                                 | <input type="checkbox"/> Rheumatic Fever                                  |   |
|   | <input type="checkbox"/> Irritable Bowel Syndrome                     |   |   |

**Surgery:**  No Surgical History

Surgery	Date	Surgery	Date

**Family History (check all that apply):**  No Family Medical History

	Family Member*		Family Member*
<input type="checkbox"/> Anemia (Low Blood Count)		<input type="checkbox"/> Hypercholesterolemia	
<input type="checkbox"/> Cancer - list type(s):		<input type="checkbox"/> Hypertension	
		<input type="checkbox"/> Osteoporosis	
		<input type="checkbox"/> Pulmonary Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Stroke Syndrome	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Thromboembolic Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Unattainable-Patient Adopted	
<input type="checkbox"/> Hepatic (Liver) Disorder		<input type="checkbox"/> Other:	
Family Health Status of Father – Deceased Age: _____ Cause: _____			
Family Health Status of Mother – Deceased Age: _____ Cause: _____			

\*Please indicate the family member affected: mother, father, brother, sister, maternal or paternal grandmother/grandfather, etc.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Social History:**

Marital Status:  Married  Single  Widowed  Separated  Divorced  Life Partner

(check all that apply)

Alcohol Use: Weekly: \_\_\_\_\_

Drug Use (Recreational): Explain: \_\_\_\_\_

Using Intravenous Drugs: Explain: \_\_\_\_\_

Previous History of Smoking: Date Quit: \_\_\_\_\_ Packs Per Day \_\_\_\_\_ Years of Smoking: \_\_\_\_\_  
Attempts to Quit: \_\_\_\_\_ Methods Used to Quit: \_\_\_\_\_

No History of Smoking  Wishing to Stop Smoking

Smoking/Nicotine Substances:  Cigarettes: Packs/Times Per Day: \_\_\_\_\_ Years \_\_\_\_\_  
 Cigars  Chewing  Tobacco  Pipe

Current Diet: Explain: \_\_\_\_\_

Exercise Habits: Times per week: \_\_\_\_\_  Being Sedentary (Do not exercise)  Sexually Active

Occupation: List All: \_\_\_\_\_

Travel: If recently out of the country, where? \_\_\_\_\_

Do you have an advanced directive?  Yes  No

**Allergies:**  No Known Allergies

Allergy	Reaction	Allergy	Reaction

**Medications** (Include vitamins, herbal supplements and over the counter medications):  No Current Medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs?  Yes  No Explain: \_\_\_\_\_

Are you pregnant?  Yes  No Last Menstrual Period Date: \_\_\_\_\_

Is there anything else about your medical history that we should know? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have reviewed the above information with the patient.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Today's Date: \_\_\_/\_\_\_/20\_\_\_

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### MEN

#### SEXUAL

Are you sexually active?  No  Yes # of current partner(s) \_\_\_\_\_  male  female  both

Do you use protection (condoms)?  Yes  No

Have you ever had a sexually transmitted disease?  No  Yes \_\_\_\_\_

Do you have problems with erectile function?  No  Yes

COLONOSCOPY most recent \_\_\_\_\_ where \_\_\_\_\_

When is your next colonoscopy due? \_\_\_\_\_

#### IMMUNIZATIONS list date of most recent

Flu \_\_\_\_\_

HPV (Gardasil) \_\_\_\_\_

Pneumonia \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Tetanus \_\_\_\_\_

Hepatitis A \_\_\_\_\_

Shingles (Zostavax) \_\_\_\_\_

Other \_\_\_\_\_

#### SOCIAL

With whom do you live \_\_\_\_\_

Number of children \_\_\_\_\_

Current stressors \_\_\_\_\_

Who is the person you go to for emotional support? \_\_\_\_\_

Have you ever been or currently are in an abusive relationship?  No  Yes

Do you exercise?  No  Yes How many times per week? \_\_\_\_\_ Duration? \_\_\_\_\_ hrs

Do you follow any particular diet? \_\_\_\_\_



# Communication of Protected Health Information

I would like Jefferson University Physicians ("Jefferson") to share my protected health information, which includes billing information, with the individuals (e.g., my spouse, parent(s), etc.) listed below.

After providing Jefferson with this completed and signed form, Jefferson agrees to communicate with the individuals listed below unless I provide Jefferson with written notice to no longer do so.

## I. Patient Identification

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## II. Authorization of Communication

I hereby grant Jefferson's Department/Division of \_\_\_\_\_ permission to communicate my protected health information to the following individuals:

Name: _____	Patient Relationship: _____
Address: _____	Phone Number(s): _____

Name: _____	Patient Relationship: _____
Address: _____	Phone Number(s): _____

Name: _____	Patient Relationship: _____
Address: _____	Phone Number(s): _____

Name: _____	Patient Relationship: _____
Address: _____	Phone Number(s): _____

Name: _____	Patient Relationship: _____
Address: _____	Phone Number(s): _____

Name: _____	Patient Relationship: _____
Address: _____	Phone Number(s): _____

I understand that completing this form is voluntary. I am not required to list any individuals.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_