Jefferson®
University Physicians

Jefferson Women's Primary Care
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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 9th & Walnut), **834 Walnut Street, Suite #110.** The entrance to 834 is on Walnut Street between 8th and 9th 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 9th 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

834 Walnut Street, Suite 110, Philadelphia, PA 19107
THOMAS JEFFERSON UNIVERSITY

Jefferson.
University Physicians

JUP Medical History Questionnaire

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

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

Surgery: ☐ No Surgical History

Surgery	Date	Surgery	Date

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

	Family Member*		Family Member*
☐ Anemia (Low Blood Count)		☐ Hypercholesterolemia	
☐ Cancer - list type(s):		☐ Hypertension	
		☐ Osteoporosis	
		☐ Pulmonary Disease	
☐ COPD		☐ Renal Disease	
☐ Diabetes Mellitus		☐ Stroke Syndrome	
☐ Emphysema		☐ Thromboembolic Disease	
☐ Heart Disease		☐ Unattainable-Patient Adopted	
☐ Hepatic (Liver) Disorder		☐ 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.**

JUP Medical History Questionnaire *(PAGE 2 OF 2)*

MRN # ______________________

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:_______________ Date:____________

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SEXUAL

Age of first intercourse__________ # Current partner(s)_____ ☐ male ☐ female ☐ both

Have you ever had a sexually transmitted infection? ☐ No ☐ Yes______________________________

PREGNANCY

None____ vaginal deliveries____ C-sections____ still births____ miscarriages____ abortions___

BIRTH CONTROL

Are you using birth control now? ☐ No ☐ Yes Method(s):______________________________

Have you had your tubes tied? ☐ No ☐ Yes Do you plan children in the future? ☐ No ☐ Yes

MENSTRUAL

First day of last menstrual period______________________ Age at onset of menses____________

Frequency of periods _______________ How many days does your period usually last?____________

Flow: spotting____ light______ moderate_____ heavy_____

PAP SMEAR

Date of last pap (Thin Prep)____________ History of abnormal pap: ☐ No o☐ Yes Date(s)____________

History of colposcopy: ☐ No ☐ Yes Date(s) and location______________________________

COLONOSCOPY Date and place of most recent:____________________________________

When are you due for your next colonoscopy?__________________

IMMUNIZATIONS list date of most recent:

Flu_______________ Shingles (Zostavax)__________ Hepatitis A____________

Pneumonia___________ HPV (Gardasil)___________ Other_______________

Tetanus_____________ Hepatitis B_____________

SOCIAL

With whom do you live__________________________________ Number of children___________

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?_____________

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: ______________