

WELCOME TO THE COMPREHENSIVE WOMEN'S CENTER



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We are very pleased that you have selected our practice. Our mission is to enhance and extend women's lives by providing the highest quality obstetrics and gynecologic services in a caring manner. Attached you will find the paperwork we need completed prior to your first visit. **Please fill out all forms and bring them to your appointment along with your insurance card.** If you have any questions when completing these forms, please contact us at the numbers below. We look forward to meeting with you soon.

Wheeling Office

1083 Lake Cook Road
Wheeling, IL 60090
(847) 808-7070 Tel
(847) 808-7474 Fax
(Intersection of Lake Cook Road and Lexington)

Hoffman Estates Office

1555 Barrington Rd., Suite 4300
Doctor's Building #3
Hoffman Estates, IL 60169
(847) 884-9800 Tel
(847) 884-0808 Fax

Comprehensive Women's Center

Patient Information

(PLEASE PRINT)

Name _____ Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Date of Birth _____ Age _____

Social Security No. _____ Marital Status S M W D

Employer _____ Work Phone _____

Email Address _____ Cell Phone _____

Referred by? Dr. _____ Friend _____ Other _____

PRIMARY INSURANCE

Ins. Company _____ Group# _____ ID# _____

Name of Cardholder _____ Date of Birth _____

Social Security No. _____

Is Your Insurance through Your Employer? Yes No Effective Date ____/____/____
(circle one)

Employer _____ Relationship to Insured _____

SECONDARY INSURANCE

Ins. Company _____ Group# _____ ID# _____

Is Your Secondary Insurance through Your Husband Parent
(circle one)

Name of Cardholder _____ Date of Birth _____

Social Security No. _____

Employer _____ Relationship to Insured _____

Insurance Effective Date ____/____/____

EMERGENCY INFORMATION

Name _____ Home Phone _____

Relationship _____ Work Phone _____

Non-Family Member Contact _____

Signature _____ Date _____

I authorize release of information to insurance carriers and/or health care providers as may be necessary to file a claim or facilitate my health care. I assign payment of benefits to CWC and understand that I am financially responsible for any balance not covered by my insurance carrier. Patient due balances are due and payable within 30 days of receipt of statement. I agree to pay all collection costs which are incurred if my account is referred to an outside collection agency. If CWC refers the collection of the balance to a lawyer, I agree to pay all lawyers fees which are incurred plus all court costs. This form is valid for one year unless rescinded or otherwise modified by you.

Signature _____ Date _____

Credit Card Information for No Show/No Call Cancellation Policy		
Name on Credit Card _____		
VISA	MASTERCARD	DISCOVER (please circle one)
Credit Card Number _____	Expiration Date _____	3 digit code _____

I wish to be contacted in the following manner (check all that apply)

- Home Telephone # _____ Written Communication
 - O.K. to leave message with detailed information
 - O.K. to mail to my home address
 - Leave message with call-back number only
 - O.K. to fax to _____

- Cell Phone _____

- Work Phone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

The doctors and staff of CWC may only speak with anyone (including your spouse) regarding your healthcare if you give us written consent. The following statement is optional.

I give CWC, its doctors and staff permission to speak with _____, my _____
Regarding my (check one or both)

- medical records, tests, and progress
- financial and/ or insurance information

PLEASE PRINT NAME _____ (DATE) _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY _____ (DATE) _____

SIGNATURE OF ADULT/GUARDIAN WITH MINOR _____ (DATE) _____

Comprehensive Women's Center

Patient Name _____

CONFIDENTIAL PERSONAL HEALTH HISTORY

MEDICAL HISTORY

Do you or did you ever have any of the following?

Check (3) if yes.

- | | <u>Dates</u> |
|--|--------------|
| <input type="checkbox"/> Anemia | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Tumor of any kind | _____ |
| <input type="checkbox"/> Cancer _____ | _____ |
| <input type="checkbox"/> Syphilis or gonorrhea | _____ |
| <input type="checkbox"/> Convulsions or epilepsy | _____ |
| <input type="checkbox"/> Frequent or severe headaches | _____ |
| <input type="checkbox"/> Blood Clots or phlebitis | _____ |
| <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Persistent Cough | _____ |
| <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Heart Disease or Murmur | _____ |
| <input type="checkbox"/> Blood Transfusion | _____ |
| <input type="checkbox"/> Rapid or Irregular Heartbeat | _____ |
| <input type="checkbox"/> Chest Pain | _____ |
| <input type="checkbox"/> German Measles | _____ |
| <input type="checkbox"/> Frequent or severe abdominal pain | _____ |
| <input type="checkbox"/> Ulcer Disease | _____ |
| <input type="checkbox"/> Gall Bladder Disease | _____ |
| <input type="checkbox"/> Yellow jaundice or hepatitis | _____ |
| <input type="checkbox"/> Bladder or kidney disease | _____ |
| <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Varicose Veins | _____ |
| <input type="checkbox"/> Easy Bruisability | _____ |
| <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Skin Disease | _____ |
| <input type="checkbox"/> Depression or Anxiety | _____ |
| <input type="checkbox"/> Unusual Hair Growth | _____ |
| <input type="checkbox"/> Recent Weight Change | _____ |
| <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Other Diseases | _____ |

MEDICATIONS (Please List)

- Cigarettes
Packs Per Day _____ How Long? _____
 How much alcohol do you consume?

Drugs

SURGICAL HISTORY

FAMILY HISTORY

Have your grandparents, parents, uncles, aunts, brothers, sisters or children ever been treated for:

Check (3) if yes.

- | | <u>Explanation & Dates</u> |
|---|--------------------------------|
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Blood Disease | _____ |
| <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Lung Disease | _____ |
| <input type="checkbox"/> Epilepsy | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Nervous Disorders | _____ |
| <input type="checkbox"/> Muscular Disorders | _____ |
| <input type="checkbox"/> Birth Defects | _____ |
| <input type="checkbox"/> History of Twins | _____ |

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CONFIDENTIAL PERSONAL GYNECOLOGY HISTORY

MENSES

Last Menstrual Period _____ Was it a normal period? _____
Age at first period _____ At present, periods are Regular Irregular
Number of days between periods _____ Duration of periods _____

ABNORMAL UTERINE BLEEDING

- My periods are prolonged (more than 7 days).
- I have excessive flow.
- My periods are greater than 35 days apart.
(from beginning of one cycle to the next)
- I have been embarrassed and/or forced to
leave a situation due to heavy bleeding.
- I have missed work and/or other
responsibilities due to my heavy periods.
- I have uterine fibroids.

Prior treatment? Yes No

If **yes**, please check all that apply:

- Birth Control Pills
- Premarin
- Provera/Depo-Provera
- Endometrial Ablation
- Hysterectomy

PAP SMEARS

Date of last pap smear _____ Was it a normal pap smear? Yes No

Have you ever had an abnormal pap smear in the past? Yes No

If **Yes**: What was the date (approximately)? _____

Were you treated? Yes No

What was the treatment? _____

PREGNANCY

Del. Date	Birth Wt.	Sex	Living Y/N	Vaginal	C/S	Early or late delivery?	Complications?

CONTRACEPTION

What contraception do you use currently? Birth Control Pills Depo-Provera/Lunelle
 Condoms Diaphragm IUD Tubal Ligation/Vasectomy Natural Family Planning
 Other _____

What contraception have you used in the past? Birth Control Pills Depo-Provera/Lunelle
 Condoms Diaphragm IUD Tubal Ligation/Vasectomy Natural Family Planning
Norplant
 Other _____

CONFIDENTIAL PERSONAL GYNECOLOGY HISTORY - Page 2

PELVIC PAIN

- I experience pain with intercourse.
- I experience moderate to severe pain with my periods.
- I am missing days from work due to the severity of my pain.
- I have significant pelvic pain not related to my period or intercourse.
- I have a history of endometriosis.

Prior treatment? Yes No

If yes, please check all that apply:

- Birth Control Pills
 - Laser surgery
 - Laparoscopy
 - Hysterectomy
 - Pain medication
-

SEXUALLY TRANSMITTED DISEASES

Have you ever been diagnosed with Gonorrhea Chlamydia Syphilis HIV
 Genital Warts Trichomonas Hepatitis Herpes

Were you treated? Yes No

Was your partner treated? Yes No

BREAST HISTORY

- I do monthly self-breast exams.
- I have annual mammograms done.
- I have a personal history of breast cancer.
- I have a family history of breast cancer.
- I have a history of fibrocystic breast disease.

Prior treatment? Yes No

If yes, please check all that apply:

Last mammogram_____

- Breast aspiration
 - Breast biopsy
 - Breast surgery
 - Surgeon's Name
-

MENOPAUSE (if applies to you)

- My periods have been irregular or absent over the last several months.
- I am experiencing hot flashes and/or night sweats.
- I have vaginal dryness and/or experience pain with intercourse.
- Since going through menopause, I have experienced spotting or vaginal bleeding.

Prior treatment? Yes No

If yes, please check all that apply:

- Endometrial biopsy
- Hormone Replacement Therapy
- Soy Protein
- Vitamin E
- Other_____

INCONTINENCE (if applies to you)

- I experience discomfort with urination.
- I have trouble making it to the bathroom without an accident.
- I often feel the urge to urinate even when the bladder is not full.
- I leak urine when I cough or sneeze.
- I leak urine when I exercise or have intercourse.
- I leak urine when I hear the sound of running water.

Prior treatment? Yes No

If **yes**, please check all that apply:

- Medication(s)
 - Incontinence Ring
 - Weighted Vaginal Cones
 - Pelvic Muscle Exercises (Kegels)
 - Biofeedback
 - Surgery
-

OSTEOPOROSIS

- I am in menopause.
- I am not currently or have never taken estrogen.
- I am Caucasian, Hispanic, Asian or Native American.
- I have a family history of osteoporosis.
- I drink greater than 3 cups of coffee per day.
- I do not exercise regularly.
- I am a smoker.
- Since the age of 45, I have had a broken bone at the hip, rib, and/or wrist.
- I have been treated for and/or been told that I have rheumatoid arthritis.

Prior treatment? Yes No

If **yes**, please check all that apply:

- Calcium
- Vitamin D
- Weight Bearing Exercise
- Hormone Replacement Therapy
- Fosomax
- Other_____

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Date: _____

Patient Name: _____

Please check one (1) of the following:

Are you here for your annual well woman/preventive exam and pap smear?

OR

Are you here for treatment of specific medical symptoms or problems?

Please check yes or no below:

Do you desire STD (sexually transmitted disease) testing?

Yes _____

No _____

Your insurance plan or policy determines your medical coverage. Please become knowledgeable about your benefits. Our responsibility is to submit a claim which reflects the services performed in this office based on coding guidelines and regulations.

Patient Signature

Date

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Notice of Privacy Practice Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: _____

**Signature of Patient: _____

Date: _____

Patient's Date of Birth: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative: _____

Relationship (parent, guardian, etc.): _____

Signature of Personal Representative: _____

Date: _____

Signature of Practice Employee

Date _____

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