WELLNESS OF CENTRAL FLORIDA

Female Patient Questionnaire & History

Name: _____Today's Date: _____

Date of Birth: _____Age: _____ Weight: _____

Home Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____ May we contact you via TEXT ( ) YES ( ) NO

E-Mail Address: _____May we contact you via E-Mail? ( ) YES ( ) NO

Preferred Pharmacy: _____Phone: _____

Primary Care Physician's Name: _____ Phone: _____

Marital Status (Check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Social:

( ) I am sexually active

( ) I want to be sexually active

( ) I have completed my family

( ) My sex has suffered

( ) I haven't been able to have an orgasm

Habits:

( ) I smoke cigarettes/cigars _____ per day

( ) I drink alcoholic beverages _____ per week

( ) I drink more that 10 alcoholic beverages a week

( ) I use caffeine _____ a day

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Medical History Continued

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) YES ( ) NO

If yes, please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

Last Medical/GYN exam (year)_____

Last Mammogram (Month/year)_____

Last Bone density (year)_____

Last Pelvic ultrasound (year)_____

High Risk Past Medical/Surgical History

( ) Breast cancer

( ) Uterine cancer

( ) Ovarian cancer

( ) Hysterectomy WITH removal of ovaries

( ) Hysterectomy only

Birth Control Method:

( ) Menopause

( ) Hysterectomy

( ) Birth control pills

( ) Vasectomy

( ) Other: _____

Medical Illnesses:

( ) Polycystic Ovary Syndrome (PCOS)

( ) High blood pressure

( ) High cholesterol

( ) Heart Disease

( ) Stroke and/or heart attack

( ) Blood clot and/or a pulmonary embolus

( ) Arrhythmia

( ) Hepatitis or HIV

( ) Lupus or other autoimmune disease

( ) Fibromyalgia

( ) Trouble passing urine

( ) Chronic liver disease (fatty liver/cirrhosis)

( ) Diabetes

( ) Thyroid Disease

( ) Arthritis

( ) Depression

( ) Anxiety

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.