



Visit Date: \_\_\_\_\_

Patient Chart: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

(First) (MI) (Last)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status:  Single  Married  Widowed  Divorced

Home Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Spouse DOB: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Pharmacy & Location: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

I give permission for The Woman's Place to contact the patient's pharmacy for a list of medications.  Yes  No

Race:  Hispanic  Asian  Caucasian  Black/African American  American Indian or Alaska Native  Other: \_\_\_\_\_

Ethnicity (Nationality-cultural background):  Hispanic/Latino  Non-Hispanic/Latino  Other

**-Complete if Student or Minor-**

**Father Information**

**Mother Information**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, St., Zip: \_\_\_\_\_ City, St., Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

**-Person Responsible for Payment of Account-**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

City, St., Zip: \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_

**-Insurance Information-**

*Please Present Card(s) for Copying*

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Address: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Address: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

I hereby give my consent to Pinnacle Sports Medicine & Orthopaedics and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Pinnacle Sports Medicine & Orthopaedics chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_



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1818 E. 23rd Ave. Hutchinson, KS 67502 620.662.2229 888.862.2224 www.thewomansplace.net

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(First) (MI) (Last)

**-Acknowledgement of Receipt of Privacy Notice-**

I acknowledge that I have received a copy of The Woman's Place Notice of Privacy Practices effective April 2003.

**-Authorization for Medical Care-**

I hereby authorize The Woman's Place to give me medical treatment for any and all conditions they deem appropriate. I understand that the doctor or other provider will discuss with me their recommendations for testing and/or treatment that in their professional judgment they feel is appropriate for my needs

**-Referral Waiver-**

I acknowledge that in the course of my treatment, The Woman's Place may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. The Woman's Place will notify me when such a referral occurs. I understand that The Woman's Place does not know whether the facility or provider they are referring me to is a contracting provider with my insurance plan. I agree that should The Woman's Place make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider that The Woman's Place refers me to contracts with my insurance company. The Woman's Place is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

**-Release of Information-**

We are often contacted and asked to give details on the patient's appointment, billing information or condition. If you are not present at the time such a request is made (e.g., over the telephone) we will follow your prior instructions in determining whether we should share any information, or we will contact you before providing any specific response.

**Please indicate your preferences below:**

- 1.  Do NOT share ANY information with anyone (self only)
- 2.  Share information with the people listed below upon their request, unless I specifically direct you, in writing, not to share certain information. (parent, spouse, children, etc)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature of Patient or Legal Representative

Relationship to patient

Date

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**Office Use Only:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

**PATIENT QUESTIONNAIRE**

Reason for today's visit (please list any symptoms that you would like to discuss with your doctor): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you trying for pregnancy:  Yes  No  Possible  Not Applicable

Are you currently pregnant:  Yes  No  Possible  Not Applicable

Do you desire STI (sexually transmitted infection) screening:  Yes  No

**History of STI**

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> HPV (abnormal pap) | <input type="checkbox"/> Genital warts |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Syphilis           | <input type="checkbox"/> HIV           |
| <input type="checkbox"/> Herpes    | <input type="checkbox"/> Trichomonas        |  |

Please list all medications which you are currently taking: (include vitamins, supplements, herbs, etc.)

Medication	Dose	Reason

Do you have any medication allergies?  Yes  No If yes, please list below:

Medication	Reaction
	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Wheezing <input type="checkbox"/> Shock <input type="checkbox"/> Stomach upset <input type="checkbox"/> Other Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Wheezing <input type="checkbox"/> Shock <input type="checkbox"/> Stomach upset <input type="checkbox"/> Other Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Wheezing <input type="checkbox"/> Shock <input type="checkbox"/> Stomach upset <input type="checkbox"/> Other Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

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### Gynecological Medical History

Last Pap: \_\_\_\_\_ First day of last menstrual cycle: \_\_\_\_\_ Age of first menstrual cycle: \_\_\_\_\_

Birth control method: \_\_\_\_\_ Age at onset of menopause (if applicable): \_\_\_\_\_

Are your periods regular? Yes No How many days do you flow? \_\_\_\_\_ Days between flow: \_\_\_\_\_

Do you have heavy periods? Yes No How many pads or tampons/day? \_\_\_\_\_

Do you have pain with periods? Yes No Does pain start before or during? Before During

Is the pain: Mild Moderate Severe

Do you have pain in between periods? Yes No Is the pain: Mild Moderate Severe

Do you have bleeding between periods? No With ovulation Just before period After period Irregular

Do you have bleeding after intercourse (sex)? Always Sometimes Never

If you are perimenopausal or menopausal, are you experiencing?

Hot Flashes Night Sweats Sleep disturbances Mood Swings Vaginal Dryness

Do you have vaginal discharge? Yes No

Type: White Yellow Brown Green Clear Thick Thin Painful Itching Burning

Do you leak urine? Yes No

If yes: With cough or laugh Spontaneously

Have you had an abnormal pap smear? Yes No Date: \_\_\_\_\_

Have you ever had cervical treatment?: Yes No Date: \_\_\_\_\_

Do you have problems with your breasts?

A mass or lump? Right Left Both

Pain? Right Left Both

Discharge from the nipple? Right Left Both

How many times have you been pregnant (including miscarriage / termination / ectopic)? \_\_\_\_\_

How many living children do you have currently? \_\_\_\_\_

### Obstetric History (list pregnancies, miscarries and abortions in order)

	Year	Type of Delivery	M or F	Weight	Complications
1					
2					
3					
4					
5					
6					
7					
8					

\*List additional information on the back



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**Please check all that apply:**

<b>Female Surgical History</b>	<input type="checkbox"/> N/A	<b>Date</b>		<b>Date</b>
<input type="checkbox"/> Total abdominal hysterectomy with or without removal of ovaries		_____	<input type="checkbox"/> Vaginal hysterectomy with or without removal of ovaries	_____
<input type="checkbox"/> Bilateral Tubal Ligation or other sterilization		_____	<input type="checkbox"/> Hysteroscopy +/- D&C	_____
<input type="checkbox"/> D and C (Dilation and Curettage)		_____	<input type="checkbox"/> Breast Reduction	_____
<input type="checkbox"/> Breast Biopsy		_____	<input type="checkbox"/> Augmentation Mammoplasty	_____
<input type="checkbox"/> LEEP/Cone Biopsy		_____	<input type="checkbox"/> Mastectomy (specify right or left)	_____
<input type="checkbox"/> Endometrial Ablation		_____	<input type="checkbox"/> Cesarean (# _____)	_____
<input type="checkbox"/> Other: _____		_____		_____
<b>General Surgical History</b>	<input type="checkbox"/> N/A	<b>Date</b>		<b>Date</b>
<input type="checkbox"/> Angioplasty		_____	<input type="checkbox"/> Gastric bypass	_____
<input type="checkbox"/> Angioplasty with stent		_____	<input type="checkbox"/> Hernia repair	_____
<input type="checkbox"/> Appendectomy		_____	<input type="checkbox"/> Hip surgery or replacement	_____
<input type="checkbox"/> Back surgery		_____	<input type="checkbox"/> Knee surgery or replacement	_____
<input type="checkbox"/> Coronary Artery Bypass Graft		_____	<input type="checkbox"/> Liver biopsy	_____
<input type="checkbox"/> Carpal tunnel release		_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Removal of gallbladder		_____	<input type="checkbox"/> Small or Large bowel resection	_____
<input type="checkbox"/> Removal of part of your colon		_____	<input type="checkbox"/> Thyroidectomy	_____
<input type="checkbox"/> Drainage of your colon to abdomen bag		_____	<input type="checkbox"/> Tonsillectomy +/- adenoids	_____
<input type="checkbox"/> Eye Surgery		_____	<input type="checkbox"/> Other: _____	_____

**Family History**

Adopted (history unknown)

<input type="checkbox"/> NONE OF THESE APPLY TO MY FAMILY	Mother	Father	Sister	Brother	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)	Child	Other
Asthma										
Alzheimer's/ Dementia										
Blood clots										
Cancer										Specify:
Diabetes										
Elevated Cholesterol										
Heart disease										Specify:
Hypertension										
Kidney disease										
Liver disease										
Lupus										
Osteoarthritis										
Osteoporosis										
Rheumatoid arthritis										
Seizures										
Stroke										

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### Social History

Highest grade completed in school? \_\_\_\_\_ Are you still in school? Yes No

Occupation: \_\_\_\_\_ Marital Status: Single Married Widowed Divorced

Who lives at home with you (specify number of daughters/sons)? \_\_\_\_\_

Tobacco Use: Current Former Never Type: Chewing Cigar Cigarette Pipe  
Amount per day: \_\_\_\_\_ Number of years used: \_\_\_\_\_ Year quit: \_\_\_\_\_

Alcohol Use: Current Never Former Type: Beer Wine Hard liquor  
How often do you drink? Daily Weekly Monthly Rarely Amount: \_\_\_\_\_

Caffeine Use: Yes No  
Type: Chocolate Coffee Energy Drinks Soda Tablets Tea Amount per day: \_\_\_\_\_

Transfusion: If medically necessary, do you agree to blood transfusion? Yes No

Illicit Drug Use: Current Never Former Age started: \_\_\_\_\_ Year quit: \_\_\_\_\_  
Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Last use: \_\_\_\_\_

History of child of abuse? Yes No Offender(s): \_\_\_\_\_ Physical Sexual Verbal

History of domestic violence? Yes No Perpetrator(s): \_\_\_\_\_

Are you sexually active? Yes No Orientation: Heterosexual Homosexual Bisexual

How many partners have you had sex with? \_\_\_\_\_ How old were you when you first had sex? \_\_\_\_\_

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**Review of Systems**

**Constitutional**

- Chills
- Fever

**HEENT**

- Blurred vision
- Double vision
- Eye pain
- Headache
- Ear infection
- Sore throat

**Respiratory**

- Asthma
- Chronic cough
- Difficulty breathing
- Wheezing

**Cardiovascular**

- Chest pain
- Irregular heartbeat Palpitations
- Edema

**Gastrointestinal**

- Constipation
- Decreased appetite
- Diarrhea
- Nausea/vomiting

**Genitourinary**

- Pain with urination
- Frequent urination
- Blood in urine
- Sexual dysfunction
- Vaginal discharge
- Vaginal itching

**Metabolic**

- Cold intolerant
- Heat intolerant
- Increased Thirst
- Weight Gain
- Weight Loss

**NONE OF THESE APPLY TO ME**  
**Neuro/Psychiatric**

- Anxiety
- Depression
- Incontinence
- Tremors
- Vision changes

**Dermatologic**

- Changing of color mole(s)
- Itching skin
- Rash
- Chronic hives

**Musculoskeletal**

- Back pain
- Joint pain
- Muscle pain

**Hematologic**

- Easy bleeding
- Easy bruising

**Health Protocol**

Please indicate if you have had any of these:

Date of Last

Date of Last

Cholesterol Screening	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Tetanus Vaccine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Stool cards for hidden blood	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Influenza Vaccine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
GYN Exam/Pap Smear	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		HPV Vaccine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Sigmoidoscopy/Colonoscopy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		DEXA Scan	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Pneumococcal Vaccine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Mammogram	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Hepatitis B Vaccine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No							