Gynecology
APD Multi-Specialty Clinic
Lebanon, NH 03766
(603) 448-3996 Fax (603) 448-7423

Thank you for choosing Gynecology at Alice Peck Day Memorial Hospital for your care. We are located on Level 2 of the Multi-Specialty Clinic at 9 Alice Peck Day Drive in Lebanon, NH. We have sent you this paperwork to become a new patient with us, to re-establish your care with us, or because we have received a referral on your behalf from another provider.

In order to help us to see patients on time and in an efficient manner, please take a few moments to fill out the enclosed forms. Be as complete as possible.

Once this completed paperwork is received, we will gladly schedule you with the first available appointment.

We look forward to your visit and hope to bring you the highest quality care possible. Thank you for doing your part to assist us in that endeavor.

New Patient Intake - Gynecology
Women's Care Center

Name:
MR#: place patient sticker here
DOB:

Patient Name:_______________________________ Date of Birth: ______________
(last name, first name, middle initial) Gender: ☐ Male ☐ Female
Mailing Address: ____
(street) (City/State/Zip)
Physical Address (if different from mailing): ______________________________

Home Phone: ______________________ Cell Phone: ______________________

Marital Status:	☐ Married	☐ Single	☐ Divorced	☐ Widow
Race:	☐ White	☐ African American	☐ American Indian	☐ Asian
Ethnicity:	☐ Hispanic/Latino	☐ Non-Hispanic/Non-Latino		

Social Security Number: ________________ Primary Care Provider: ________________
Primary Language: ________________ E-Mail address: ________________
Employer: ________________ Occupation: ________________
Work Phone: ________________
Preferred Pharmacy: ________________
Preferred Name (what do you prefer we call you, if different than above): ________________

FIRST INSURANCE INFORMATION:
Plan Name: ________________ Policy Number: ________________
Address: ________________ Group Number: ________________
Policy Holder: ________________ Policy Holder's Date of Birth: ________________
Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's SS #: ________________
Policy Holder's Relation to Patient: Effective Date: ________________

SECOND INSURANCE INFORMATION:
Plan Name: ________________ Policy Number: ________________
Address: ________________ Group Number: ________________
Policy Holder: ________________ Policy Holder's Date of Birth: ________________
Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's SS #: ________________
Policy Holder's Relation to Patient: Effective Date: ________________

PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILL (Complete only if different from patient):

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DOB:

Name: ________________________ Social Security Number: ____________________
Address: ____
Home Phone: ____________________ Relation to Patient: ______________________

PRIOR HEALTH CARE/ADVANCE DIRECTIVES:
Last Primary Healthcare Provider- Name & Location: ___________________________
Do you have a Living Will: ☐ Yes ☐ No
Do you have a Durable Power of Attorney for Health Care: ☐ Yes ☐ No
If yes, who: ________________________ Relationship: ______________________
Phone number:------------

(Please Print)

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DOB:

Your Name (Last):________________ (First):________________ (M.I.):________

Date of Birth:________________ Referred Here by:________________________

I Attest That the Information Here Is True and Correct to The Best of My Belief.

________________________________ ________________
Patient Signature Date

Past Medical History

(If you have ever had any of these conditions – Please check all that apply)

Breast Conditions:
- ☐ Abnormal Mammogram
- ☐ Breast Cancer: ☐ Left ☐ Right
- ☐ Breast Implants
- ☐ Fibrocystic Breasts
- Other:________________

Gyn Problems:
- ☐ Abnormal Pap Smear
- ☐ Cervical Cancer (Neoplasm)
- ☐ Dysmenorrhea (Painful Menses)
- ☐ Endometrial (Uterine) Cancer
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Herpes
- ☐ Human Papilloma Virus Infection (HPV)
- ☐ Ovarian Cancer
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Sexually Transmitted Disease (STD)
- ☐ Vaginal Cancer (Neoplasm)
- ☐ Vulvar Cancer (Neoplasm)
- Other:________________

Blood (Hematologic) Disorders:
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Clotting Disorder
- ☐ Sickle Cell Trait or Disease
- ☐ Thalassemia
- Other:________________

Endocrine (Glandular) Disorders:
- ☐ Diabetes – Type I (Insulin-Dependent)
- ☐ Diabetes – Type II
- ☐ Pituitary Gland Disorder
- ☐ Thyroid Disease (Hypo) or (Hyper)
- ☐ High Cholesterol
- Other:________________

Immune System Diseases:
- ☐ Chronic Fatigue Syndrome
- ☐ Sinus Allergies
- ☐ Systemic Lupus
- ☐ Rheumatoid Arthritis
- Other:________________

Gastrointestinal (GI) Problems:
- ☐ Colitis, Ulcerative
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Irritable Bowel Syndrome
- Other:________________

Neurologic Disorders:
- ☐ Common Migraines
- ☐ Headaches (Other)
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder (Epilepsy)
- ☐ TIA or Stroke
- Other:________________

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(If you have ever had any of these conditions – Please check all that apply - continued)

Heart or Circulation Conditions (Cardiovascular):
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ CVA (Stroke)
- ☐ Hypertension (High Blood Pressure)
- ☐ Irregular Heart Beat
- ☐ Mitral Valve Disorders (MVP)
- ☐ Pulmonary Embolism (Blood Clot in Lung)
- ☐ Thrombophlebitis (Blood Clot in Extremity)

Other:____________________________

Psychiatric or Emotional Conditions:
- ☐ ADHD/ADD
- ☐ Bipolar (Manic-Depressive)
- ☐ Major Depression
- ☐ OCD (Obsessive-Compulsive)
- ☐ Postpartum Depression
- ☐ Severe Anxiety or Panic Attacks

Other:____________________________

Urinary (Urological) Disorders:
- ☐ Calculus (Kidney Stones)
- ☐ Pyelonephritis
- ☐ Stress Incontinence
- ☐ Urge Incontinence/Overactive Bladder
- ☐ Urinary Tract Infections (UTI)

Other:____________________________

Musculoskeletal Disorders:
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Systemic Lupus Erythematosus

Other:____________________________

Respiratory (Lung) or ENT Disorders:
- ☐ Asthma
- ☐ COPD
- ☐ Lung Cancer
- ☐ Pneumonia - Recurrent
- ☐ Sleep Apnea
- ☐ Tuberculosis

Other:____________________________

Skin Conditions:
- ☐ Acne (Severe)
- ☐ Eczema
- ☐ Hirsutism (Excess Hair Growth)
- ☐ MRSA
- ☐ Psoriasis

Other:____________________________

Genetic Disorders:
- ☐ Cystic Fibrosis
- ☐ Muscular Dystrophy

Other:____________________________

Past Surgical History
(Please include any D&C, D&E, Colposcopy, Cryotherapy or Colonoscopy Surgeries)

Surgery	Reason	When

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DOB:

Herbs, Vitamins and Supplements You Are Taking

Product Name	Dose (if known)	How Often	Start Date	Reason

Medications You Are Taking

Drug Name	Dose (if known)	How Often	Start Date	Prescribed By

Primary Pharmacy Name:______________________________ Phone:__________
Pharmacy Address:____

Allergies

Do You Have Any Known Medication Allergies? ☐Yes ☐No
Are you allergic to any of the following (check all that apply): ☐Contrast Dye ☐Nickel
☐Peanuts ☐Latex ☐Iodine ☐Shellfish ☐Adhesive Tape ☐Band Aids
Other:____

Please list all allergies and the allergic reaction:

Allergic To (medications, foods, environmental)	Reaction

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Family Medical History

If **Any** close relative (Brothers, Sisters, Parents, Children, Grandparent [Maternal or Paternal], Aunt/Uncle) Has Ever Had or Currently Has any of the problems listed below, place a check and enter the relationship to you

Condition	Yes	No	Who (be specific)
Endometriosis	☐Yes	☐No	Who (be specific):________
Uterine Fibroids	☐Yes	☐No	Who (be specific):________
Breast Cancer	☐Yes	☐No	Who (be specific):________
Colon Cancer	☐Yes	☐No	Who (be specific):________
Heart Disease	☐Yes	☐No	Who (be specific):________
High Blood Pressure	☐Yes	☐No	Who (be specific):________
High Cholesterol	☐Yes	☐No	Who (be specific):________
Blood Clots	☐Yes	☐No	Who (be specific):________
Diabetes – Type I	☐Yes	☐No	Who (be specific):________
Diabetes – Type II	☐Yes	☐No	Who (be specific):________
Hyperthyroidism	☐Yes	☐No	Who (be specific):________
Hypothyroidism	☐Yes	☐No	Who (be specific):________
Lung Cancer	☐Yes	☐No	Who (be specific):________
Depression	☐Yes	☐No	Who (be specific):________
Bipolar Disorder	☐Yes	☐No	Who (be specific):________
Other Malignancies (Site):________	☐Yes	☐No	Who (be specific):________
Ovarian Cancer	☐Yes	☐No	Who (be specific):________
Uterine Cancer	☐Yes	☐No	Who (be specific):________
Endometrial Cancer	☐Yes	☐No	Who (be specific):________
Osteoporosis	☐Yes	☐No	Who (be specific):________

Menstrual History

Menopause Status: ☐Premenopausal ☐Postmenopausal ☐Perimenopausal
Age Menopause:________

Are You Sexually Active? ☐Yes ☐No With: ☐Men ☐Women ☐Both

Age of First Menstrual Period:________ Cycle Length (28 days or?):________

Number days of bleeding with a period________ Period Flow: ☐Light ☐Medium ☐Heavy

Date of Last Normal Menstrual Period (if abnormal describe):________

____

Birth Control Method Using Now:________

(*Period Means # Days of Bleeding; Cycle Length Means Total # of Bleeding and Non-Bleeding Days Until the Next Period Begins)

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DOB:

Pregnancy Summary (How Many…?)

Total # of Pregnancies	Full Term Births (more than 37 weeks)	Premature Births (less than 37 weeks)	Terminations	Miscarriages (was surgery needed?)	Ectopic Pregnancies (left or right?)	Number of Living Children

(please provide date of terminations, miscarriages and ectopic pregnancies)

Comments:____

Pregnancy Details

Child's Birthdate (mm/dd/yr)	Child's Name	# Weeks At Delivery	Length of Labor	Birth Weight	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications or Problems	Physician	Location

Social History

Marital Status: ☐Dating ☐Divorced ☐Engaged ☐Married ☐Not Dating ☐Separated ☐Single ☐Widowed ☐Living with Significant Other

Alcohol Use: ☐Never ☐Current ☐Former
How Much:__________ Age Started:________ Age Stopped:________

Illegal Drug Use: ☐Never ☐Current ☐Former
Which Drug(s):____________________
How Often:__________ Age Started:________ Age Stopped:________
When Last Used:____________________

Tobacco Use: ☐Never ☐Current ☐Former
How Much:__________ Age Started:________ Age Stopped:________

Caffeine Use: ☐Yes ☐No How Much:____________________

Exercise Habits: ☐Sedentary ☐Active but no formal exercise
☐Minimal Amount of Exercise (once weekly or less)
☐Moderate Amount of Exercise (1-3 times weekly)
☐Heavy Amount of Exercise (4 or more times weekly)
Type of Exercise:____________________

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DOB:

Occupation:____

Hobbies:____

Check If You Currently Have Any of the Following Symptoms

CONSTITUTIONAL:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue/Weakness
- ☐ Fever

EYES:
- ☐ Vision problem

HENT:
- ☐ Headaches

BREAST:
- ☐ Breast Lumps
- ☐ Breast Pain
- ☐ Breast Discharge
- ☐ Leaking Milk

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Short of breath on exertion
- ☐ Heart murmur
- ☐ Swelling in legs

RESPIRATORY:
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ Cough

ALLERGIC-IMMUNOLOGIC:
- ☐ Sinus allergy symptoms

GENITOURINARY:
- ☐ Not having periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Bleeding between periods
- ☐ Painful periods
- ☐ Pelvic pain
- ☐ Pain with intercourse
- ☐ Spotting with or after intercourse
- ☐ Decreased sex drive
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Difficulty starting to urinate
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Leaking urine with cough
- ☐ Leaking urine with urge

INTEGUMENTARY:
- ☐ Rash
- ☐ Itching
- ☐ New skin lesions
- ☐ Changes in existing moles

NEUROLOGIC:
- ☐ Seizures
- ☐ Dizziness
- ☐ Syncope (Fainting/Passing out)

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DOB:

Check If You Currently Have Any of the Following Symptoms (continued)

GASTROINTESTINAL:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stool

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Muscular weakness

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes

ENDOCRINE:
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Loss of hair
- ☐ Changes in hair texture
- ☐ Changes in skin texture
- ☐ Excessive hair growth

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

Well Woman Screening History

Please Indicate the Date of Your Last:

Pap:_______________________________________

Mammogram:_______________________________________

Colonoscopy:_______________________________________

Lipid Screening:_____________________________

Glucose Test:_______________________________________

Dexa (Bone) Scan:___________________________________