APD Gynecology - Women's Care Center
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 gynecologic care. We are located at 9 Alice Peck Day Drive in Lebanon, NH. We have sent this paperwork to you 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):

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)

New Patient Intake - Gynecology
Women's Care Center

Name:
MR#: place patient sticker here
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:____________________

(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

New Patient Intake - Gynecology
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Name:
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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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DOB:

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)

New Patient Intake - Gynecology
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Name:

MR#: place patient sticker here

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:________________________________

New Patient Intake - Gynecology
Women's Care Center

Name:

MR#: place patient sticker here

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)

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:___________________________

Dartmouth-Hitchcock Health

Dartmouth-Hitchcock Affiliated Covered Entity

Permission to Share Protected Health Information

PATIENT INFORMATION:

Patient Name: ______________________________

Date of Birth: ______________________ Phone: ( ) ______________

Street Address: ______________________________

City: ______________ State: ________ Zip: ________

FACILITY:

Please check the current location of the records you want shared:

☐ Alice Peck Day ☐ Cheshire Medical Center ☐ DH-Concord ☐ DHMC-Lebanon ☐ DH-Manchester ☐ DH-Nashua

☐ New London Hospital ☐ Other: ______________________________

RECIPIENT: I authorize the entities listed above to release my information to:

Name of Person or Entity: ______________________ Phone Number: ( ) ______________

Street Address: ______________________________

City: ______________ State: ________ Zip: ________

PURPOSE:

☐ Medical care ☐ Payment of health insurance claim ☐ Workers' Comp ☐ Legal ☐ Personal ☐ Disability determination

☐ Life insurance application ☐ Transfer of Care ☐ Other (please specify):______________________________

INFORMATION TO BE SHARED:

☐ VERBAL COMMUNICATION

☐ MEDICAL RECORDS

The records to be released will cover the time period from ______________________to______________________

☐ Records from a specific provider: ______________________________

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ School/Camp Form	☐ Other: ______________
☐ Inpatient Notes	☐ Lab/Path Reports	☐ Radiology Reports	______________
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	______________
☐ Billing	☐ Immunizations	☐ Photos	

Delivery: ☐ Patient Portal (myD-H) (*FREE!*) ☐ Pickup ☐ Mail to Recipient ☐ Fax Number: (________)______________________

Format: ☐ Paper ☐ CD

DURATION & REVOCATION:

My authorization is valid for one year from the date of my signature below, unless I specify a different date here: ________________.
My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

I understand that:

- A fee for the cost of processing this request may be charged.
- D-H ACE members will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- D-H ACE members may utilize a business associate/authorized agent to assist in fulfilling this request.

SENSITIVE HEALTH INFORMATION This form authorizes D-H ACE members to release the following types of information, **UNLESS** you place your initials in the space provided:

__________ psychiatric treatment records

__________ genetic testing

__________ HIV/AIDS test results

__________ sexually transmitted disease (STD) treatment records

__________ substance use disorder treatment records from a 42 CFR Part 2 program

____
Signature of Patient or Personal Representative

____
Date

____
Printed Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

"Dartmouth-Hitchcock Health (D-HH)" is the corporate parent of the covered entities listed below, each of which is an individual corporate entity legally separate and distinct from Dartmouth-Hitchcock Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and D-H Clinic, operating jointly as "Dartmouth-Hitchcock," Mt. Ascutney Hospital and Health Center, New London Hospital, and the Visiting Nurses and Hospice for VT and NH. The D-H ACE comprises only of D-HH members who are currently using a single, integrated electronic medical record system, sometimes referred to as "eD-H."

INSTRUCTIONS:
How to fill out "Permission to Share Protected Health Information" authorization form

This form should be used when you want your medical records held by us to be sent to a third party.

Please complete all sections. An incomplete authorization may result in a delay in processing your request.

PATIENT INFORMATION

Complete each section as indicated with the following information:

- Patient's name (please print clearly)
- Patient's Date of Birth
- Telephone number where requester can be reached during the day
- Patient's Mailing Address, including City, State, and Zip Code

DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY (D-H ACE) FACILITY

Please tell us the current location of the records that you want shared.

Alice Peck Day	**Cheshire Medical Center**	**Concord**	**Dartmouth-Hitchcock Medical Center**	**Manchester**	**Nashua**	**New London Hospital**
Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 448-7433 Fax: (603) 640-1984	HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-5478	Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	Release of Information 1 Medical Center Dr. Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869	Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 676-4290	Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 577-4039	Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051

RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient's or Business Entity's (Company's) Name. If the information is for your own personal use, write "Self."
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

PURPOSE

Check the box that best describes the purpose for sharing your health information. If no box relates to your purpose, check "Other" and state the purpose for the release on the line provided. **This section must be filled out in order for the form to be valid.**

INFORMATION TO BE SHARED

- Indicate whether you are authorizing verbal communications or medical records release, or both.
- Fill in the date range that applies to the health information you are requesting we share.
- Check the box(es) that apply to your request.
- You can tell us you want your records from only a specific provider by checking the "Records from a specific provider" box and filling in the relevant provider's name.

DELIVERY: Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

FORMAT: Please indicate whether you want the records in paper format or in electronic format (PDF) on an encrypted CD.

DURATION & REVOCATION

Your authorization will remain valid for one year from the date of your signature, unless you specify a different date in the space provided. You have the right to revoke your permission at any time. Please revoke by following the directions in our Notice of Privacy Practices, available on our website, or contact the Privacy Office at PrivacyOffice@hitchcock.org or 1-844-754-8250.

ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

SENSITIVE HEALTH INFORMATION

If you do not place your initials in the space provided, we **WILL** release sensitive information contained in your medical record as necessary to fulfill your request. For more information on how we share your sensitive information, please refer to our Notice of Privacy Practices, available on our website, or contact the Privacy Office at PrivacyOffice@hitchcock.org or 1-844-754-8250.

SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign this form, depending on the type of care received.

If you are not the patient, describe your relationship to the patient and legal authority to sign. In some cases, you will be required to provide legal paperwork verifying your authority (e.g., court-appointed guardian, power of attorney for health care, appointment from court of executorship/administrator of decedent's estate).