ALICE PECK DAY
MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

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.

ALICE PECK DAY MEMORIAL HOSPITAL
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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):

ALICE PECK DAY MEMORIAL HOSPITAL
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New Patient Intake - Gynecology Women's Care Center

Name:
MR#: place patient sticker here
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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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

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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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New Patient Intake - Gynecology Women's Care Center

Name:
MRN: place patient sticker here
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

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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Name:
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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:_____

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 Health

PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH HEALTH

Use this form when you want your records sent to Dartmouth Health from another provider/facility.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Ph: _____

Address: _____

City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider/Facility: _____

_____

Address: _____ City: _____

State: _____ Zip: _____ Fax: (_____) _____

RECIPIENT:

To share (disclose) my health information with Dartmouth Health, please send my records to the following Dartmouth Health member location:

❑ **Alice Peck Day** Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 308-0026 Fax: (603) 640-1970 Email: medicalrecords@apdmh.org	❑ **Cheshire Medical Center** HIM Department 590 Court Street Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 676-4253 Email: cmcroi@cheshire-med.com	❑ **Dartmouth Hitchcock Medical Center** Release of Information 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869 Email: Lebanon.Release.of.Information@ hitchcock.org	❑ **Hanover Psychiatry** 23 S. Main St., Suite 2B Hanover, NH 03755 Ph: (603) 277-9110 Fax: (603) 277-9154

❑ **Manchester, Nashua & Concord - DH** Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 727-7828 Email: DH-ROI@hitchcock.org	❑ **New London Hospital** Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051	❑ **Newport Health Center** Release of Information 11 John Stark Highway Newport, NH 03773 Ph: (603) 865-2855 Fax: (603) 863-3585	❑ **Visiting Nurse and Hospice for VT/NH** Release of Information 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869 Email: Lebanon.Release.of.Information@ hitchcock.org

If mailing my information, please return requested records to the following department/section or provider:

_____

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

- ❑ Discharge Summary
- ❑ Inpatient Progress Notes
- ❑ Outpatient Visit (Office) Notes
- ❑ Other: _____
- ❑ Emergency Department Reports
- ❑ Laboratory/Pathology Reports
- ❑ School Physical Forms
- ❑ Records from a Specific Provider: _____
- ❑ Immunizations
- ❑ Operative Reports
- ❑ X-Ray Reports
- ❑ X-Ray Films

For the following purpose: _____

SENSITIVITE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Dartmouth Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:**

- _____ Mental health treatment records
- _____ Genetic testing
- _____ HIV/AIDS test results
- _____ Sexually transmitted disease (STD) treatment records
- _____ Alcohol/drug abuse treatment records

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: _____ (date). I or my Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Dartmouth Health and _____ **[SENDER NAME]** will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. My sending healthcare provider may require fees to process my request.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority