Valley Women's Center

Athens-Limestone Hospital

1005 W. Market St. Ste. 17
Athens, AL 35611
Phone: 256-233-5000
Fax: 256-233-5361

Welcome to Valley Women's Center,

Please complete the attached new patient paperwork & bring it with you to your appointment.
We also ask that you bring your medications and/or a list of them, your driver's license and insurance cards, and be prepared to pay your co-payment as it is due at the time of service.

If you have any questions, please call our office during normal business hours. Hours of operation are as follows:

Monday-Thursday: 8AM-4:30PM
Monday-Thursday: Closed for lunch from 12PM-1:00PM
Friday: 8AM-12PM

We look forward to caring for you!

Valley Women's Center Staff

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Maiden Name: (if applicable) _____ Date of Birth: _____ SSN: _____

Marital Status: (Please circle) Single Married Divorced Widowed Separated

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Telephone (Home): (_____) _____ Telephone (Cell): (_____) _____

Telephone (Work): (_____) _____

How do you prefer to be reminded of your appointments? (Please Circle:) Phone Call Text

Race: (Please Circle:) Caucasian African American Native American Alaskan Asian Native Hawaiian Pacific Islander Decline Other: _____

Primary Language: (Please Circle:) English Spanish Other: _____

Student: (Please Circle:) Full-Time Part-Time

Employment: (Please Circle:) Full-Time Part-Time Self Employed Retired Unemployed

Employer: _____ Occupation: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Primary Care Provider: _____ Referred by: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Telephone (Primary): (_____) _____ Telephone (Secondary): (_____) _____

MEDICAL INSURANCE INFORMATION:

Primary Coverage

Insurance Company Name: _____ Copay Amount $_____

Contract Number/Member ID/Benefits Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to Policy Holder: _____ SSN: _____

Secondary Coverage

Insurance Company Name: _____ Copay Amount $_____

Contract Number/Member ID/Benefits Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to Policy Holder: _____ SSN: _____

OFFICE POLICIES

*Please **initial** after reading each policy:*

Initial below

- If you arrive 15 minutes after your scheduled appointment time, you will be asked to reschedule, unless prior arrangements with our office have been made. _____
- Any patient who does not cancel her appointment at least 24 hours before the scheduled time is considered a no-show. $25.00 will be charged for no-show visits and must be paid before future appointments can be scheduled. Any patient who is a no-show 5 or more times may be dismissed from the practice. _____
- All copays are due at the time of service. _____
- In the event that you establish care with a different OB/GYN physician, you will no longer be allowed to schedule an appointment with our office. This does not include a second opinion visit. _____
- Please request school or work excuses for the day of your appointment before you leave the office. _____
- Medical forms and medical record requests require a minimum of 6 – 10 business days to process. _____
- **Calls are not made notifying patients of normal results but such information will be available through the Patient Portal or over the phone if the patient chooses to call our office.** _____
- Pregnancy deductible and co-insurance payments are due no later than the 36th week of pregnancy. _____
- Picture Identification and insurance card(s) must be brought with you to all scheduled appointments. _____
- If you need a prescription refilled, please contact your pharmacy to get them to send a refill request.

Thank you for complying with our office policies. We appreciate our patients!

Signature: _____ Date: _____

AUTHORIZATION TO FILE INSURANCE

I authorize Valley Women's Center to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical/surgical services. I certify that the information I have reported with regard to my insurance information is correct. I acknowledge that I am responsible for payment of any services not covered by my insurance and that it is my responsibility to know which services may not be covered by my insurance policy.

☐ Agree ☐ Disagree

AUTHORIZATION TO LEAVE MESSAGES

I authorize Valley Women's Center to leave messages regarding my medical condition such as lab results, other test results, medications, and appointment reminders on my home answering machine or cell phone.

☐ Agree ☐ Disagree

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize Valley Women's Center to obtain my prescription history from my pharmacy.

☐ Agree ☐ Disagree

ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES AND PATIENT RIGHTS

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
Your signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all information listed above. Signature below also indicates that you have received a copy of the Patient Rights and Responsibilities for Athens-Limestone Health Services Clinics/Valley Women's Center.

Please list up to three people below that you give us permission to give your billing information to (insurance information, balance owed, etc.) and up to three people that you give us permission to give your medical information to (appointment times, test results, refill requests, etc.). If you do not wish to list anyone, please write "none".

	Name	Relationship
MEDICAL INFORMATION:	_____	_____
	_____	_____
	_____	_____
BILLING INFORMATION:	_____	_____
	_____	_____
	_____	_____

Signature: _____ Date: _____

Valley Women's Center
1005 West Market Street
Suite 17
Athens, Alabama 35611
Phone: (256)233-5000
Fax: 256-233-5361 /256-262-6099

Health History

Today's Date: _____

Patient Name: _____ DOB: _____

Reason for today's visit: _____

_____

First day of your last menstrual period: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Medications: ☐ NOT TAKING ANY MEDICATIONS

Please list all medications you are currently taking including OTC vitamins & supplements.
(If you have a list of your medications, please attach copy.)

Name and Strength of medication:	How often? Daily, Twice a day, Every 6 hours, PRN

Allergies: ☐ NO KNOWN ALLERGIES

Please list any drugs, foods, environmental or dietary allergies, and the reaction it caused.

Medication Name:	Reaction:

Immunizations

Are your immunizations up-to-date? Yes____ No____

COVID-19? Yes____ No____ Pfizer Moderna J&J

Gardasil (HPV) immunization? Yes____ No____

Pneumonia vaccine? Yes____ No____

When was your last flu shot? (Month/Year) _____

Who is your Primary Care Physician? _____ Phone #_____

Past Medical History

Do you have or have you ever had any of the following? (Circle "yes" or "no")

AIDS or HIV+	Yes	No	High Blood Pressure	Yes	No
Anxiety	Yes	No	High Cholesterol	Yes	No
Asthma	Yes	No	Hypothyroidism	Yes	No
Anemia	Yes	No	Irritable Bowel Syndrome	Yes	No
Bleeding Disorders	Yes	No	Migraine headaches	Yes	No
Blood transfusions	Yes	No	Mitral Valve Prolapse	Yes	No
Cancer Type:_____	Yes	No	Osteoarthritis	Yes	No
Chronic pain	Yes	No	Osteoporosis	Yes	No
COPD	Yes	No	Polycystic Ovarian Disease	Yes	No
Coronary Artery Disease	Yes	No	Recurrent UTI's	Yes	No
Deep Vein Thrombosis	Yes	No	Seizures	Yes	No
Depression	Yes	No	Sleep apnea	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Endometriosis	Yes	No	Thyroid Disease	Yes	No
Fibromyalgia	Yes	No	Tuberculosis	Yes	No
GERD	Yes	No	Urinary Incontinence	Yes	No
Heart Attack	Yes	No	Ulcers	Yes	No

Other medical condition(s) not listed:

_____

_____

Obstetric History

Total # of Pregnancies	Full Term Deliveries (Over 37 weeks)	Premature Deliveries (Less than 37 weeks)	Abortions	Miscarriages	Ectopic	Multiple Births (Twins, Triplets, etc.)	# of Living Children

Number of Vaginal Deliveries: _____ Number of Cesarean Sections: _____

Please list any complications/problems with pregnancies or deliveries:

_____

_____

_____

_____

Gynecological History

Age Period began: _____ Age at Menopause: _____ (if applicable)

How frequently do you have a cycle? _____ (enter number of days from first day of cycle to first day of next)

How many days do your periods last? _____ Days

Please circle your answer beside each question listed below:

Are your periods: Regular Irregular

Cramping: None Minimal Moderate Heavy

Is your flow: Light Moderate Heavy

How often do you change a pad or tampon? _____ times a day

Are you currently sexually active? Yes No

Have you been sexually active in the past? Yes No

Do you have sex with: Men Women Both

How many sexual partners have you had in the **last year**: none 1 fewer than 5 5-10 greater than 10

How many sexual partners have you had in **your lifetime**: none 1 fewer than 5 5-10 greater than 10

Current method of contraception:

Abstinence - Birth control pills - Condoms - Depo-Provera - IUD - Natural family planning - Nexplanon Implant - NuvaRing - Patches - Tubal sterilization – Hysterectomy - Vasectomy - None

Other: _____

Preventative Health Maintenance

When was your last: (Month/Year)	What was the outcome? Normal	Abnormal
Pap smear: _____	_____	_____
Mammogram: _____	_____	_____
Colonoscopy: _____	_____	_____
Bone Density Scan (DEXA): _____	_____	_____

Have you ever had an abnormal pap smear? Yes No

Did you have any further testing or treatment done? (repeat pap smear, colposcopy, LEEP, cryotherapy)

If so, When? _____ ***Where?*** _____

What was the outcome of the results? _____

Have you ever had an abnormal mammogram? Yes No

Did you have any further testing? (diagnostic mammogram, additional views, ultrasound, biopsy)

other: _____

Surgical History

(Please circle any past surgeries and include year)

Hysterectomy	_____	Tonsils/Adenoids Removed	_____
Ovaries Removed	_____	Hernia Repair	_____
Bladder Sling	_____	Wisdom Teeth Removed	_____
Gallbladder Removed	_____	Breast Augmentation	_____
Appendix Removed	_____	Other: Please Specify	_____
Cesarean Section	_____	Other: Please Specify	_____

Family History

Do you have a family history of any of the following: (mother, father, sibling, grandparent(s)?
Please specify if family member is maternal (mother's side of family) or paternal (father's side of family)?
Ex: Maternal Grandmother or Paternal Aunt, Paternal Grandfather, Maternal Aunt

Breast Cancer	Yes	No	_____
Colon Cancer	Yes	No	_____
DVT/PE's (DVT)	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Hypertension	Yes	No	_____
Ovarian Cancer	Yes	No	_____
Uterine Cancer	Yes	No	_____

Social History

Marital status_____ Occupation_____ Employer_____

Number of children_____

Do you currently exercise? Yes No If yes, how often? _____

Do you smoke? Yes No If yes, how many packs per day? _____ How many years? _____

Are you a past smoker? Yes No Quit date: _____

Do you drink alcohol? Yes No *If yes, how much?* Occasional Moderate Heavy

Do you consume caffeine? Yes No *If yes, what type and how often?* _____

Do you use illegal drugs? Yes No *If yes, what type and how often?* _____

Do you suffer from anxiety, depression, panic attacks, or any other mental illness? _____

_____

Have you ever had any of the following sexually transmitted diseases?

Please circle: Yes No

Chlamydia Genital Warts Gonorrhea Hepatitis Herpes HIV HPV Syphilis Trichomoniasis Other:_____

If so, when? _____

Treated? Yes No

Have you ever been a victim of domestic/sexual abuse? Yes No If yes, when? What form?

_____

REVIEW OF SYSTEMS

Name: _____ DOB: _____

Are you currently experiencing any of these symptoms? Please select all that apply:

General

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Unintentional weight loss
- ☐ Unintentional weight gain
- ☐ Other _____

Cardiovascular

- ☐ Chest pain
- ☐ Difficulty breathing while walking
- ☐ Palpitations
- ☐ Excess fluid/Swelling
- ☐ Other _____

Gastrointestinal

- ☐ Abdominal pain
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Nausea
- ☐ Vomiting
- ☐ Unable to control bowel movements
- ☐ Other _____

Genitourinary

- ☐ Painful periods
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Abnormal vaginal bleeding
- ☐ Frequent urination
- ☐ Leak urine when coughing/sneezing
- ☐ Abnormal vaginal discharge
- ☐ Urinary urgency
- ☐ PMS
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Musculoskeletal

- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Other _____

Skin/Breast

- ☐ New or unusual mole
- ☐ Dry skin
- ☐ Breast lump
- ☐ Breast skin changes
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Other unusual skin lesions
- ☐ Other _____

Endocrine

- ☐ Hair loss
- ☐ Heat/Cold intolerance
- ☐ Hot flashes
- ☐ Decreased libido
- ☐ Other_____

Neurologic

- ☐ Difficulty walking
- ☐ Dizziness/Lightheadedness
- ☐ Headaches
- ☐ Severe memory problems
- ☐ Numbness
- ☐ Seizures
- ☐ Other _____

Lymphatic

- ☐ Easy bruising
- ☐ Enlarged lymph node(s)
- ☐ Other _____

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Mood changes
- ☐ Other _____

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Please answer <u>all</u> of the following questions and bring this paperwork with you to your appointment. Your first appointment will be with a nurse. They will go over all of your medical history and any questions you may have.

Name: _____ **Date of Birth:**_____

Husband/ Father of Baby: _____ **Phone Number:**_____

Emergency Contact:_____ **Phone Number:** _____

Pharmacy: _____ **Location:** _____

First day of your last menstrual period: _____ **Was it normal in duration? (Circle) Yes No**

Are your cycles generally regular? (Circle) Yes No

How frequently do you have a cycle? (Number of days between FIRST day of one period to the first day of the next) _____ **days**

Were you using any form of birth control when you conceived? (Circle) Yes No

Age when you began having periods: _____ **Date of positive pregnancy test:**_____

Your Medical History

Please check the appropriate box for the following medical problems

	Yes	No		Yes	No
Diabetes			**Alcohol Use**		
High Blood Pressure			**Illicit/Recreational Drugs**		
Heart Disease			**Rh Sensitized (Mom negative blood- Baby positive blood & mother never received Rhogam)**		
Autoimmune Disorder			**Seasonal Allergies**		
Kidney Disease or Chronic UTI			**Drug/ Latex Allergies**		
Neurological/Epilepsy			**Breast Problems**		
Psychiatric			**Gynecological Surgery**		
Depression/Postpartum Depression			**Operations/Hospitalizations**		
Hepatitis/Liver Disease			**Anesthesia Complications**		
Varicose Veins			**History of Abnormal Pap Smear**		
Thyroid Disease			**Uterine Abnormality**		
Trauma/Violence			**Infertility**		
Had a Blood Transfusion			**ART (Infertility Treatments)**		
Tobacco use			**Relevant family history**		

Please explain any of the above, if needed:

_____

_____

_____

Infection/Risk Assessment

	Yes	No		Yes	No
Live with someone with or exposed to TB			**History of Successful Vaginal Birth after C-Section**		
Patient or partner have history of genital herpes			**Tobacco Use (since conception)**		
Rash or viral illness since Last menstrual period			**Maternal Drug Use**		
Hepatitis B, C			**Interpreter needed**		
History of STD			**Previous LEEP**		
History of Gonorrhea			**Previous Stillbirth**		
History of Chlamydia			**Rubella Non Immune**		
History of HPV			**History of trauma, drug use, domestic violence**		
History of Syphilis			**Previous Pre-Term Delivery**		
Other			**History of Diabetes**		
Previous C- Section			**History of Pre Eclampsia (high blood pressure in pregnancy)**		
Previous miscarriage			**Rh Negative Blood Type**		
Previous Ectopic Pregnancy					

Please explain any of the above, if needed:

_____

_____

_____

Genetic Screening

	Yes	No		Yes	No
Patient will be over 36 years old at time delivery			**Huntington's Chorea**		
Thalassemia (Italian, Greek, Mediterranean, or Asian Background)			**Mental Retardation / Autism**		
Neural Tube Defect (Spina Bifida, Anencephaly, etc.)			**Other Inherited Genetic or Chromosomal Disorder**		
Congenital Heart Defect			**Maternal Metabolic Disorder (Type 1 Diabetes, PKU)**		
Down Syndrome			**Patient or baby's Father had a child with any birth defects not listed above**		
Tay-Sachs Disease (Ashkenazi Jewish, Cajun, French Canadian)			**Recurrent Pregnancy Loss, or a Stillbirth**		
Canavan Disease (Ashkenazi Jewish)			**Medications/ Illicit/ Recreational Drugs/ Alcohol since last menstrual period**		
Familial Dysautonomia (Ashkenazi Jewish)			**Other**		
Sickle Cell Disease or Trait			**Previous LEEP**		
Hemophilia or other blood disorders					
Muscular Dystrophy					
Cystic Fibrosis					

Please explain any of the above, if needed:

_____

_____

_____

Past Pregnancies

Total # of Pregnancies	Full Term Deliveries (over 37 weeks)	Premature Deliveries (Less than 37 weeks)	Abortions	Miscarriages	Ectopic	Multiple Births	# of Living Children

Please provide the following information for <u>each</u> of your past pregnancies

Date of delivery	*How many weeks at delivery*	*Length of labor (hours)*	*Birth weight of baby*	*Gender of baby*	*Vaginal Delivery or Cesarean Section*	*Type of anesthesia (ex. epidural)*	*Place of delivery*	*Preterm labor (yes/no)*	*Complications (yes/no)*

Pregnancy Planning

- If needed, is a blood transfusion acceptable? (Circle One:) Yes No
- Are you allergic to Latex? (Circle One:) Yes No
- Are you planning on having an epidural? (Circle One:) Yes No
- If you have a boy, would you like to have him circumcised? (Circle One:) Yes No
- Do you plan on breastfeeding or bottle-feeding, or a combination of both? (Circle One:) Breast Bottle Both