Amoskeag Women's Health
OBSTETRICS & GYNECOLOGY

Please provide us with your driver license and insurance card so we can make copies.

PERSONAL INFORMATION		NOTES
FIRST NAME		
LAST NAME		
PREFERRED NAME		
DATE OF BIRTH		
SOCIAL SECURITY NUMBER		
COMMUNICATION	☐ Text ☐ Cell ☐ Home ☐ Email ☐ Letter	
PHONE NUMBER (CELL)		
PHONE NUMBER (HOME)		
EMAIL ADDRESS		
HOME ADDRESS		

We would like to thank who referred you.

HOW DID YOU FIND US?		NOTES
SOURCE	NAME	
☐ Website		
☐ Newspaper or Magazine Ad		
☐ Community Event		
☐ Community Organization		
☐ Current Patient		
☐ Health Care Provider		
☐ Hospital Emergency Room		
☐ Insurance Listing		

Who is your Primary Care Provider?

PRIMARY CARE PROVIDER		
NAME	PHONE NUMBER	ADDRESS

Do You Need Your Labwork Sent To A Specific Lab?

Laboratory		
QUEST	LABCORPS	OTHER

Please include all medications (prescription, over-the-counter, herbal), foods, and environmental.

ALLERGIES								
#	NAME	REACTION				SEVERITY		
		RASH	HIVES	SWELLING	BREATHING	MILD	MODERATE	SEVERE
1								
2								
3								
4								
5								

Please include all medications (prescription, over-the-counter, herbal), vitamins and supplements.

MEDICATIONS						
#	NAME	Rx	OTC	DOSE	FREQ	WHY YOU TAKE THIS
1						
2						
3						
4						
5						

MEDICAL HISTORY		ADDITIONAL INFORMATION
☐ Cancer	☐ Bowel Problems	
☐ Menopause Symptoms	☐ Ovarian Cysts	
☐ Low Bone Density	☐ Pelvic Pain	
☐ Stroke	☐ Painful Intercourse	
☐ Seizures	☐ Endometriosis	
☐ Migraines	☐ Painful Periods	
☐ Thyroid Disease	☐ Heavy Periods	
☐ Asthma	☐ Premenstrual Syndrome	
☐ Heart Disease	☐ Fertility Problems	
☐ High Blood Pressure	☐ Urinary Leaking	
☐ High Cholesterol	☐ Abnormal Pap Smears	
☐ Diabetes	☐ Uterine or Vaginal Prolapse	
☐ Kidney Problems	☐ Other	

SURGICAL HISTORY						
#	DATE	HOSPITAL	CITY	SURGEON	PROCEDURE	NOTES
1						
2						
3						
4						
5						

OBSTETRIC HISTORY														
#	DATE	HOSPITAL	CITY	PROVIDER	GA	NAME	SEX	WT	VAG	C/S	GDM	HTN	PPH	COMPLICATIONS
1														
2														
3														
4														
5														
6														

GA=Gestational Age; GDM=Gestational Diabetes; HTN=Hypertension; PPH=Postpartum Hemorrhage

FAMILY HISTORY							
RELATIVE	CANCER				COAGULATION		OTHER
	BREAST	OVARY	UTERUS	COLON	BLEEDING	CLOTTING	
Grandmothers							
Grandfathers							
Mother							
Father							
Siblings							
Children							

SOCIAL HISTORY							
Emergency Contact	☐ Name			☐ Phone			
Significant Other	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	☐ Other	
Adopted Children	☐ Name			☐ Name			
Step-Children	☐ Name			☐ Name			
Employed	☐ Employer			☐ Position			
Smoking	☐ Never	☐ Previous	☐ Current	☐ Packs/Day			
Alcohol >3 Drinks/wk	☐ Never	☐ Previous	☐ Current	☐ Drinks/Week			
Pets	☐ Name			☐ Breed			
Exercise	☐ Type			☐ Frequency			
Sports & Activities	☐ Type			☐ Frequency			
Hobbies	☐ Type			☐ Frequency			
Seat Belt	☐ Always	☐ Sometimes	☐ Never				
Abuse	☐ Never	☐ Previous	☐ Current	☐ Physical	☐ Verbal	☐ Emotional	☐ Sexual
Do You Feel Safe?	☐ Always	☐ Sometimes	☐ Never				

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PERSONAL INFORMATION	
FIRST NAME:	LAST NAME:
DATE OF BIRTH:	**SOCIAL SECURITY NUMBER:**

Release Options

☐ Release records to Primary Care Physician (no charge).

☐ Release records at your request for a fee ($15 up to 30 pages + $.50 for each additional page).

RELEASE MEDICAL RECORDS TO			OBTAIN MEDICAL RECORDS FROM		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:		Phone:	Fax:	

DATES OF RECORDS TO BE RELEASED				
☐ All Dates	☐ Specific Dates	☐ Date Range	From	To
PURPOSE OF RECORDS TO BE RELEASED				
☐ Transfer of Care	☐ Concurrent Care	☐ Personal Records	☐ Other	
SPECIFIC RECORDS TO BE RELEASED				
☐ All Records	☐ Ultrasounds	☐ Pap Smears	☐ Operative Reports	
☐ Laboratory Results	☐ Pathology Reports	☐ Bone Density Scan Report	☐ Other (Specify)	
☐ PCP Package Annual Exam Mammogram Pap Smear Lab Results		☐ Pregnancy Package ACOG Flowsheet Delivery Summary Ultrasounds Operative Reports		

I UNDERSTAND THAT

➡ Amoskeag Women's Health will treat me even if I decline to sign this authorization.

➡ I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged pursuant to **NH State Law Chapter 332-I section 332-I:1**.

➡ Once I authorize the disclosure of my health information, it is no longer considered protected information and re-disclosure by the recipient is legally permitted.

➡ I can revoke this authorization at any time by submitting a request in writing to Amoskeag Women's Health. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires 12 months from the date of signature.

➡ The released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS treatment. The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:

☐ Drug ☐ Alcohol ☐ STD ☐ HIV ☐ Psychiatric ☐ Genetic

Date	Signature Patient/Representative	Relationship/Authority