Women's and Children's Physicians of Naples **Patient Information Sheet**

Please fill out all necessary information

Patient Information

Last Name | **First Name** | **Middle** | **Preferred / Nickname**

Maiden Name | **Prefix** Mr. Ms. Mrs. Miss | **Age** | **DOB** | **SEX** M F | **SSN**

Race | **Marital Status** | **Driver's License** | **Primary Language** | **Religion**

Address Information

Address | **City / State / Zip** | **County** | **Country**

Phones:

Home | **Work** | **Cell** | **Primary** | **Fax**

Email | **Birthplace / Hometown**

Other Information:

Employer Name | **FT/PT** | **Occupation** | **Phone / Ext.** | **Hire Date**

Spouse/Signifigant Other Name | **DOB** | **SSN** | **Driver's License** | Insurance Policy Holder **Yes** **NO**

Employer Name | **FT/PT** | **Occupation** | **Phone / Ext.** | **Hire Date**

Emergency Contact | **Relation** | **Phone**

Insurance Information:

Primary Insurance Carrier

Insurance Company | **Policy Holder** | **Policy Number** | **Group Number**

I hereby authorize Women's and Children's Physicians of Naples to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount assigned to me by my insurance or any amount for services that are not covered benefits under my insurance plan.

Signature | Date

AUTHORIZATION AND CONSENT TO OBTAIN MEDICAL INFORMATION FOR:

Women's and Children's Physicians of Naples
Louis F. Foley, M.D., F.A.C.O.G.
Jennifer M. Foley, M.D., F.A.A.P.
1217 Piper Boulevard, Suite 202
Naples, FL 34110
Telephone (239) 566-7272
Fax (239) 319-2001

TO: (physician or hospital)

_____

_____

_____

Patient Name: _____ Chart#: _____

Social Security #: _____ Birth date: _____

The information requested below will be used/disclosed for the following purposes: Ongoing medical care

I HEREBY REQUEST AND AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION: (PLEASE CHECK APPROPRIATE AREAS)

( )	History and Physical Exam	( )	Progress Notes
( )	Discharge Summary (Date: _____)	( )	Telephone Calls/Nurse & MD Notes
( )	Insurance Verification/Determination	( )	Laboratory Reports
( )	Significant Other Evaluation	( )	Report to Referral Source
( )	Psychiatric/Psychological Records	( )	Operative Report (Date: _____)
( )	Other (please specify): _____	( )	Correspondence (please specify): _____

I hereby authorize release of the above information, including psychiatric, alcohol, or other drug dependency history or treatment, and HIV/AIDS antibody testing results, to and/or from Women's and Children's Physicians of Naples, and hereby release the above from all legal liability that may arise from the release of the information requested. If, in the judgment of the medical staff, disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation, or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including, but not limited to, insurance companies and/or third party reviewers. I further authorize disclosure of information to the program's insurance carrier when so requested by the carrier.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above stated purpose, this consent will automatically expire one year from the date signed. I further understand that Women's and Children's Physicians of Naples reserves the right to notify the above named person, corporation, or agency of my revocation in the event that I revoke this consent to release information.

Patient/Parent/Guardian: _____ Date: _____

Please Print Name: _____ Date: _____

Women's and Children's Physicians of Naples

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Women's and Children's Physicians of Naples originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that service billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand, upon my request, I will be provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Women's and Children's Physicians of Naples is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Women's and Children's Physicians of Naples reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Women's and Children's Physicians of Naples change their notice, they will send a copy of any revised notice to the address I've provided, (whether U.S. mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient Signature Date

Women's & Children's Physicians of Naples

NAME:_____ **DATE:**____/____/____ **BIRTHDATE:**____/____/____

REFERRED BY:_____ **AGE:**_____

REASON FOR VISIT: ☐ **ROUTINE PHYSICAL** ☐ **PROBLEM** **DESCRIBE PROBLEM:** _____

_____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO		YES	NO
Anemia			Hepatitis / Jaundice		
Anxiety			High Blood Pressure		
Arthritis / Joint pain			High Cholesterol		
Asthma			Kidney Infections		
Blood transfusions			Kidney Stones		
Bowel Trouble			Mood Disorders		
Breast Cancer			Pneumonia		
Cancer			Rheumatic Fever		
Chronic Lung Disease			Sexually Transmitted Diseases		
Depression			Stroke		
Diabetes			Tuberculosis - TB		
Fracture			Thyroid Disease		
Glaucoma			Ulcers		
Heart Murmur			OTHER:		
Heart Trouble					

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Abnormal PAP Smear		Tetanus	
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		Last PAP Smear	
Flu Shot		TB Skin Test	
Pneumonia		OTHER:	

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON	DATE	SURGERY / REASON	DATE

NAME:_____ **BIRTHDATE:**_____/_____/_____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)		List:			

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	**WHAT RELATIVE? AT WHAT AGE?**
Anemia			
Arthritis / Joint pain			
Asthma			
Bowel Trouble / Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

YOUR GYN HISTORY

Do you use birth control? ☐ Yes ☐ No	
❑ Condoms	❑ Nuvaring
❑ Depo Provera	❑ Birth Control Patch
❑ Diaphragm	❑ None
❑ IUD- Kind	❑ Natural Family Plan/Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
– Name:	❑ Withdrawal
❑ Contraceptive Foam/Jelly	❑ Other:
What age did you have your first period: _____	
How many days are there from start of period to start of next period: _____ days	
How long does your period last?_____ days	Flow: ☐ Light ☐ Medium ☐ Heavy
Number of Tampons per day: _____	Number of Pads per day: _____
Date of Last Period: _____	
Do you have clots? ☐ Yes ☐ No	Do you have breakthrough bleeding? ☐ Yes ☐ No
Do you have cramps? ☐ Yes ☐ No	Do you have pain? ☐ Yes ☐ No
Have you gone thru Menopause: ☐ Yes ☐ No	At what age: _____
Are you on Hormone Replacement Therapy (hormones)? ☐ Yes ☐ No	

NAME:_____ **BIRTHDATE:**_____/_____/_____

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature		Abortions Induced	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.
If you have had a tubal ligation, previous hysterectomy, or if you are postmenopausal you may skip to the next section.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type Vag/CSection	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1					M F						
2					M F						
3					M F						
4					M F						
5					M F						
6					M F						

SOCIAL HISTORY

PLEASE LIST HABITS	
Do you use Seat Belt ☐ Yes ☐ No	
Do you do a Self Breast Exam ☐ Yes ☐ No	
Do you Drink Milk ☐ Yes ☐ No Glasses per day:	
Do you Eat cheese or other dairy products ☐ Yes ☐ No Servings per day:	
Do you Take Calcium ☐ Yes ☐ No Name and Dosage:	
Do you Exercise: ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week	
Are you Sexually Active ☐ Yes ☐ No Do you have sex with? ☐ Men ☐ Women ☐ Both	
First Intercourse at Age: _____ Frequency: _____ Week	
New sexual partner ☐ Yes ☐ No	
Lifetime sexual partners ☐ Less than 5 ☐ More than 5	
Smoking ☐ Yes ☐ No Packs per day: _____ Number of Years: _____	
Alcohol ☐ Yes ☐ No Drinks per day: _____ Drink per week: _____	
Drug User ☐ Yes ☐ No Kind: Frequency:	
History of abuse ☐ Yes ☐ No ☐ Physical ☐ Emotional ☐ Sexual	
List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List:

NAME:_____ **BIRTH DATE:** ____/____/_____

REVIEW OF SYSTEMS:
PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW.

CONSTITUTIONAL		**NOTES**
Weight Loss	❑	
Weight Gain	❑	
Fever	❑	
Fatigue	❑	
Night Sweats	❑	
Hot Flashes	❑	
EYES		
Double vision	❑	
Vision changes	❑	
HENT		
Headaches	❑	
Dizziness	❑	
Sore Throat	❑	
Sinus Pain	❑	
Nose Bleeding	❑	
Thyroid Mass	❑	
Neck Pain	❑	
BREAST		
Lumps	❑	
Tenderness	❑	
Swelling	❑	
Discharge	❑	
Pain in Breast	❑	
Abn Changes in Breast	❑	
CARDIOVASCULAR		
Chest Pain	❑	
Irregular Heart Beats	❑	
Rapid Heart Rate	❑	
Fainting	❑	
Swelling of legs	❑	
Varicose veins	❑	
RESPIRATORY		
Wheezing	❑	
Cough	❑	
Shortness of breath	❑	
Spitting up blood	❑	
GASTROINTESTINAL		
Nausea	❑	
Vomiting	❑	
Diarrhea	❑	
Constipation	❑	
Abdominal Pain	❑	
Bloody / Black Stool	❑	
Hemorrhoids	❑	
Jaundice	❑	
GENITOURNARY		
Urgency of urination	❑	
Frequency of urination	❑	
Pain with urination	❑	
Nighttime urination	❑	
Losing urine	❑	
Blood in urine	❑	

GENITOURNARY (CONT)		**NOTES**
Decreased sex drive	❑	
Painful intercourse	❑	
Possible Pregnancy	❑	
Genital Sores	❑	
SKIN		
Rashes	❑	
Itching	❑	
Skin Dryness	❑	
Skin Lesions	❑	
Changes to Lesions or Moles	❑	
Acne	❑	
NEUROLOGICAL		
Muscular Weakness	❑	
Numbness or Tingling	❑	
Difficulty Concentrating	❑	
Memory Difficulties	❑	
Speech Difficulties	❑	
Seizures	❑	
Loss of Balance	❑	
MUSCULOSKELETAL		
Joint Pain or Swelling	❑	
Muscle Pain	❑	
Back Pain	❑	
ENDOCRINE		
Loss of Hair	❑	
Difficulty Tolerating Cold	❑	
Difficulty Tolerating Heat	❑	
PSYCHIATRIC		
Anxiety	❑	
Depression	❑	
Impulsive Behavior	❑	
Suicidal Thoughts	❑	
Excessive Anger	❑	
Mood Swings	❑	
Emotional Abuse	❑	
Physical Abuse	❑	
Sexual Abuse	❑	
HEMATOLOGIC/ LYMPHATIC		
Bruises, frequent or easily	❑	
Cuts do not stop bleeding	❑	
Enlarged lymph nodes	❑	
ALLERGIC/IMMUNOLOGIC		
Frequent illness	❑	
Seasonal Allergies	❑	
OTHER		
1.	❑	
2.	❑	
3.	❑	