Female Health Associates of North Texas

Patient Demographics

Name:	Date of Birth:
SSN:	Marital Status:
Address:	Primary Phone Number:
E-Mail Address:	Alternate Phone Number:
Preferred Language:	EMERGENCY CONTACT & relation to you:
Race:	EMERGENCY CONTACT NUMBER:
Ethnicity:	☐ Authorization for Release of Medical Information (please check for consent)
Driver's License # and State:	Preferred Pharmacy & Phone Number
Primary Insurance Plan:	Secondary Insurance Plan:
Member ID:	Member ID:
Group Number:	Group Number:
Subscriber & Date of Birth:	Subscriber & Date of Birth:
Primary Care Provider & Phone Number:	
Who can we thank for referring you?	

Patient Name: Date of Birth:

Financial Agreement, Assignment of Benefits, Privacy Practice Agreement and Cancellation Policy

Financial Agreement Statement of Terms:

I understand it is my responsibility to know my insurance benefits and services rendered. Any charged service not covered by my insurance is my responsibility and is expected to be paid in full within thirty days of services rendered. It is my responsibility to notify Female Health Associates of North Texas of any changes to demographic or insurance information.

Assignment of Benefits

Your insurance is considered a method for reimbursing patient fees and NOT a substitute for payment. It is your responsibility to pay any deductible, co-insurance or any balance deemed patient responsibility for any laboratory testing or procedures performed in office.

Privacy Practice

Our office, physician and staff are committed to securing the privacy of your health information. Upon request our privacy practice is available.

Cancellation Policy

All appointments and procedures are scheduled with ample amount of time for each patient. Appointments, bladder studies or cystoscopy cancelled less than 48 hours are subject to $75 cancellation fee. Any surgery or in office surgical procedure cancelled in less than ten business days are subject to $150 cancellation fee.

No Show Policy

Every patient is allowed 15 minutes grace period for appointments. Any time past the 15 minute grace period, we reserve the right to reschedule your appointment for the next available time. Patients are given a one time courtesy No Call/ No Show grace. Any patient who No Call/ No Show, arrive more than 15 minutes late greater than three times are subject to a $75 Cancellation Fee. Should you No Show to your scheduled surgery or procedure you will be charged the FULL amount of the surgery/ procedure cost.

Female Health
Associates
of North Texas

We thank you in advance for your cooperation and understanding as we appreciate our patients time. Thank you for choosing *Female Health Associates of North Texas* for your healthcare needs.

Patient Name and Signature	**Date**
Staff Name and Signature	**Date**

Patient Name: Date of Birth:

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Medical History

Please check all below that apply:

☐ Skip this section I am completely healthy without any conditions mentioned below

	Anemia		Osteoporosis
	Asthma/ Bronchitis		Other:
	Blood or Black Bowel Movement		Problems with muscles, bones, nerves/joints
	Cancer		
	Depression		Psychiatric Problems
	Diabetes		Seizure Disorder
	Gallstones		STD
	Headaches		Stomach Disorder
	Heart Disease		Stroke
	Hearing Problem		Thrombophlebitis/ Blood Clot
	Hepatitis		Thyroid Disorder
	Hernia		Visual Problems
	Hypertension		Vomited Blood
	Kidney Stones		

Allergies:

List any allergies with type of reaction below or check box: ☐ No Known Drug Allergies

Medication History (Please list all current medications):

Menstrual History:

Do you have menstrual periods?					**Yes**	**No**
Date of last menstrual period:						
If you have periods, are they:	**regular**	**irregular**	**heavy/moderate**		**scant**	**painful**
If irregular periods, for how long?			**Years**			**Months**
If you have painful periods, does the pain occur:			**before**	**after**	**during**	menses?
If you no longer have menstrual periods: **hysterectomy** or **surgical removal of ovaries**? (please circle)						
Do you take or have you taken hormone replacement therapy?					**Yes**	**No**
Are you sexually active?					**Yes**	**No**
Current form of birth control?						
When was your last pap smear?			(Results)		**Normal**	**Abnormal**
Have you ever had an abnormal pap smear in the past?					**Yes**	**No**
If yes, what year and treatment plan?						
Are you experiencing any abnormal vaginal discharge or discomfort?					**Yes**	**No**
Do you have a feeling of vaginal pressure or fullness?					**Yes**	**No**
Date of last mammogram?			(Results)		**Normal**	**Abnormal**

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Surgical, Social & Family History

Past Surgeries or Hospitalizations (If none check the box next to none)

	NONE	Negative Surgical and Hospitalizations

Please list with date(s):

FAMILY HISTORY (check illness which has occurred in any blood relative and their relation to you):

□ Negative Family History			Adopted, Family History Unknown
	Birth Defect:		Lung Problems:
	Breast Cancer:		Osteoarthritis:
	Cancer, Other:		Ovarian Cancer:
	Diabetes:		Rheumatoid Arthritis:
	Heart Disease:		Seizure Disorder:
	High Blood Pressure		Skin Disease:
	Kidney Problems:		Stroke:
	Other:		Thrombophlebitis:

Social History (please circle):

Marital Status:		Married	Single	Divorced	Widowed	Separated
Alcohol Use:	Yes	No	Daily	Weekly	Amount	
Caffeine Use:	Yes	No	Daily	Weekly	Amount	
Drug Use:	Yes	No	Daily	Weekly	Amount	
Exercise:	Yes	No	How many times per week?			
Tobacco Use:	Yes	No	Daily	Weekly	Amount	
Have you ever smoked?	Yes	No	When did you quit?			

Pregnancy History

Total # of pregnancies:	# of Vaginal
# of miscarriages	# of Cesarean
#of abortions	# of premature births
# of living children	
Problems with pregnancy ?	

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BLADDER SYMPTOM QUESTIONNAIRE

☐ Skip this section, I have no bladder/ kidney or urinary symptoms.

How often do you urinate:		Daytime
		Night
Do you leak urine (incontinence)?	Yes	No
Duration of incontinence?	Years	Months
Is it caused by coughing, laughing, sneezing, running, sports, etc.?	Yes	No
Do you have difficulty starting your urinary flow?	Yes	No
Do you strain to void your urine?	Yes	No
Do you feel that you empty your bladder completely?	Yes	No
Do you notice dribbling of urine after voiding?	Yes	No
Do you need to wear protective pads for this type of incontinence?	Yes	No
If yes, how many pads do you wear on average per day?		
What activities cause you to lose control of your urine?		
Sight, sound or feel of running water	Yes	No
Standing up after being seated or laying down	Yes	No
"key in the door" when you return home	Yes	No
Do you lose urine without any warning?	Yes	No
When urinating, can you usually stop your stream?	Yes	No
Do you have frequent urinary tract infections?	Yes	No
How often have these occurred in recent years?		Per Year
Do you ever see blood in your urine?	Yes	No
Has urine leakage limited your ability to :		
Do household chores	Yes	No
Recreation such as walking, biking, exercise	Yes	No
Travel more than 30 minutes from home	Yes	No
Participate in social activities outside your home	Yes	No
Participate in, enjoy or feel comfortable with sex	Yes	No

Reason for visit: